# Report Regarding — Jeanne Bean

## Background

My name is Chelle Wilhelm, M.D. I received my M.D. from the University of Mississippi School of Medicine in 2007. I trained in internal medicine, pulmonary medicine, and allergy/immunology at the University of Mississippi Medical Center. I am licensed to practice medicine in Mississippi, board certified in Internal Medicine, Pulmonary Medicine, and Allergy/Immunology. I am a member of the American College of Allergy, Asthma, and Immunology, the American Academy of Allergy, Asthma, and Immunology, and the American College of Chest Physicians.

I am currently a practicing physician at Mississippi Asthma and Allergy Clinic, P.A. in Jackson, Mississippi. Attached to this report as Exhibit 1 is my curriculum vitae, which sets forth in greater detail my education, training, and publications.

I charge $500 per hour for records review, $1,000 per hour for medical clinic visits with plaintiffs and report drafting, and $1,500 per hour for testimony at trial.

## Allergic Rhinitis and Pulmonary Disease Related to Mold

As an allergist/immunologist, I routinely care for and treat patients with allergic rhinitis and various severity levels of asthma. I also care for and treat patients with other pulmonary disease related to mold, predominantly including Allergic Bronchopulmonary Aspergillosis (ABPA). I accordingly have extensive experience with the diagnosis and treatment of allergic rhinitis, asthma, and ABPA. Since I began practice, I have diagnosed and treated hundreds of patients with allergic rhinitis and asthma.

Allergic rhinitis is a common condition that is especially prevalent throughout the state of Mississippi. Allergic rhinitis is characterized by the allergic inflammation that involves a very complex set of immune cells, antibodies, and cytokines. However, at the center of an allergic response is the production of allergic immunoglobulin, known as IgE, to various allergens, including tree/grass/weed pollens, dog, cat, dust mites, cockroach, molds, etc. While there are other immune cells involved, the predominant cells include mast cells and eosinophils. Symptoms of allergic rhinitis include nasal congestion, runny nose, postnasal drainage, sneezing, and ocular pruritis and watering. These symptoms are triggered when a person who has been exposed to and has developed IgE antibodies to various allergens are exposed to these allergens in the environment. These allergens will bind to the IgE found on the surface of mast cells, and trigger them to release internal allergy mediators, including but not limited to histamine and leukotrienes. These mediators then mediate the allergic response and cause the person to have nasal congestion, sneezing, ocular pruritis, etc.

Asthma is also a common condition that can have various underlying cellular mechanisms. The most common form of asthma is known as allergic eosinophilic asthma and is characterized by elevated total IgE levels and specific IgE levels for various allergens, as well as elevated eosinophils. With this type of asthma, symptoms can be triggered much like the allergic rhinitis response with IgE antibodies and exposures to allergens that the person is sensitized to. If

exposed to a known allergen, this can trigger a person to have wheezing, cough, dyspnea, and chest tightness, the most common symptoms of asthma. Allergic bronchopulmonary aspergillosis is a complex pulmonary illness that is characterized by a noninfectious inflammatory response to mold organisms that are inhaled from the environment on an everyday basis. This illness is characterized by severe persistent asthma, often very difficult to control with standard therapy; elevated IgE and IgG antibody levels to aspergillus; and classic pulmonary findings, including central bronchiectasis, on high resolution CT scans of the chest.

Molds that are associated with disease in humans, including allergic rhinitis and asthma, as well as other mold mediated disease states, include, but are not limited to Aspergillus, Cladosporium, Bipolaris and Penicillium. Stachybotrys molds are not typically associated with allergic disease. These molds are sometimes erroneously referred to "toxic molds" because some species may produce mycotoxins. Stachybotrys and mycotoxins have been studied by the Centers for Disease Control and Prevention and no scientific studies have ever demonstrated a causal link between these molds that produce mycotoxins (known as toxigenic molds) and human disease. Molds are present at all times in our environment, some molds being predominantly outdoor molds while others are predominantly indoor molds. All people are exposed to molds on a daily basis, more so in different geographic locations, seasons and climates. Humidity levels influence allergen levels, particularly molds and house dust mites. High humidity environments, such as the Mississippi Gulf Coast, promote mold growth and increased house dust mite prevalence.

In my clinical practice, as I encounter patients with signs and symptoms of allergic rhinitis and asthma, there is a standard that is followed. The most important part of my visit with any patient is a clinical history to determine exactly what issues the patient may be having. Based on the history, this will lead me to any needed medical testing. Typically, this will include aeroallergen skin prick testing or aeroallergen in-vitro testing. Skin testing involves scratching the skin with the various aeroallergens to see if the patient will have an allergic response to the aeroallergen, i.e. a positive test. Testing by lab involves measuring the allergy antibody (IgE) level to the specific aeroallergens. If I am concerned about asthma or other pulmonary issue, this evaluation will include spirometry and/or chest imaging, typically a chest X-ray. These tests will then help guide treatment options and counseling on any environmental changes.

The standard treatment for allergic rhinitis includes antihistamine medications, antileukotriene medications, and intranasal corticosteroid and antihistamine sprays. The typical medications for asthma include inhaled corticosteroids, various long-acting and short-acting bronchodilators, and often times, bursts of oral corticosteroids and biologic therapies depending on the severity level. If a patient has allergic bronchopulmonary aspergillosis, often times, they require oral corticosteroids for 3-6 months in addition to some of the above therapies, followed by various bursts of oral steroids to maintain control.

With the abundance of information now available, especially with social media, it can be very difficult to separate fact from fiction regarding many topics, including mold. It is critically important to realize that exposure to mold does not necessarily mean people will be symptomatic, especially considering all homes have molds. Included is an excerpt from the Center for Disease Control and Prevention website.

"The term 'toxic mold' is not accurate. While certain molds are toxigenic, meaning they can produce toxins, (specifically mycotoxins), the molds themselves are not toxic or poisonous. Hazards presented by molds that may produce mycotoxins should be considered the same as other common molds which can grow in your house. There's always a little mold everywhere – in the air and on many surfaces. There are very few reports that toxigenic molds found inside homes can cause unique or rare health conditions such as pulmonary hemorrhage or memory loss. These case reports are rare, and a causal link between the presence of the toxigenic mold and these conditions has not been proven." www.cdc.gov/mold/stachy.htm.

**Medical History**

Mrs. Jeanne Bean is a 59 year old (at the time of my medical interview on June 6, 2019) Caucasian woman, who was seen as part of the Rule 35 examination regarding complaints of mold-related injuries from living in a home at 119 O'Donnell Drive. Review of the lease agreement reveals they were in this home from July 2, 2014 to August 31, 2016.[1] During our interview, she reported a past medical history of Graves' disease. She reported a thyroidectomy, and now takes a thyroid pill for hypothyroidism. Review of medical records did not show any notes regarding this; however, at a GI appointment on 11/8/06, it was mentioned that she had Graves' disease and was status-post thyroidectomy.[2] At a routine annual visit with her primary care provider on 3/19/18, it was noted that she had acquired hypothyroidism, and the plan was to continue levoxyl.[3] During our interview, she also reported a history of gastroesophageal reflux (GERD) treated with Nexium. At the same GI visit above, she was noted to have GERD.[4] At another GI visit on 10/5/15, she was reported to have GERD, and an EGD and colonoscopy were planned for other GI symptoms, including lower abdominal pain, constipation, and diarrhea.[5] Her EGD revealed chronic gastritis, and her colonoscopy showed sigmoid diverticuli and external hemorrhoids with melanosis coli seen on biopsy.[6] She also recounted having hypertension (HTN) and taking two medications for this, but she could not recall the names. Review of medical records indicate she was seen for HTN as early as 9/25/09 and was given lisinopril/HCTZ.[7] During my medical record review, her most recent visit with her primary care provider that was seen was on 3/19/18. During this time, she was on Maxide and Prinivil.[8] She also reported taking a medicine for elevated cholesterol, but again, she could not recall the name of the medicine. At the visit on 3/19/18, it was noted that she was on Mevacor.[9]

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[1] Bean Initial Disclosures 622-623.

[2] Bean-Jeanne Bean-M000579-000580.

[3] Bean-Jeanne Bean-M000481-000485.

[4] Bean-Jeanne Bean-M000579-000580.

[5] Bean-Jeanne Bean-M000035-000037.

[6] Bean-Jeanne Bean-M000051-000054.

[7] Bean-Jeanne Bean-M000110-000111.

[8] Bean-Jeanne Bean-M000481-000485.

[9] Bean-Jeanne Bean-M000481-000485.

During our interview, she reported allergy issues for years. She reported nasal congestion, sneezing, and ocular pruritis. She also reported anosmia as well as a decreased sense of taste. She stated that she takes singulair and Flonase daily with antihistamines as needed. During our interview, she also reported that these symptoms are year-round with no seasonal pattern, and the symptoms all worsened while living in the Keesler home. She reported sinus surgery in 2015, with slight improvement after surgery. She reported development of headaches while living in the O'Donnell home, and that this was a new issue she had never had trouble with before. Review of medical records revealed clinic visits as far back as 2001 for these symptoms. On 9/12/01, she was seen by an allergist in Tennessee for the loss of smell, as well as congestion, runny nose, ocular itching and watering, headaches, and a decreased sense of taste. She was started on Nasonex, astelin, prolex-D as needed, and Claritin or Allegra.[10] At that time, she had positive skin prick testing for weed pollen, dust mites, and cockroach, and positive intradermal testing for tree and grass pollens and cat, as well as the 4 mold mixes that were tested on intradermal testing.[11] She had a telephone consult on 10/8/01 for fullness of ears, sore throat, clear drainage, head congestion, and cough.[12] She was seen by the allergist again on 10/19/01 for follow up, and prolex-D and astelin were stopped, and Claritin and Nasonex were continued.[13] She was again seen by allergy on 8/25/05 for sinus infections, decreased smell, ocular watering and itching, nasal and ear congestion, drainage. She reported, at that time, that all symptoms had been present for five years.[14] She had repeat skin prick testing done. The skin prick testing was completely negative with a weak histamine response, and she declined intradermal testing.[15] At the next allergy follow-up visit on 10/6/05, she was continued on Nasonex, astelin, and singulair, and an ENT referral was placed.[16] She was seen by ENT on 11/1/05 for anosmia for five years. She was given a higher dose of prednisone, and an MRI brain was ordered due to anosmia.[17] This was done on 12/7/05 and was normal.[18] She was seen again in follow-up on 12/9/05 and reported no improvement in anosmia on a month-long

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[10] Bean Supp. Medical Records00001-00002.

[11] Bean-Jeanne Bean-M001073. On intradermal testing, Mrs. Bean had a grade 4 reaction to the panels containing Elm, Hackberry, Mulberry, Willow, Poplar, Sycamore, Ash, Privet, Maple, Box Elder, and Dust Mite. She had a grade 3 reaction to the panels which included Pecan, Hickory, Walnut, Cedar, Pine, Bermuda, Johnson, Kentucky Blue, Meadow Fescue, Orchard, Cat, Alternaria, Helminthosporium, Cladosporium, Aspergillus, Penicillium, Fusarium, Rhizopus, Curvularia, Pullularia, Mucor, Chaetomium, Botrytis, Geotrichum, Rhodotorula, and Phoma. She had a grade 2 reaction to the panels containing Birch, Tag Alder, Oak (Mix), Hazelnut, Beech, Ragweed Mix, Marshelder, Cocklebur, Wormwood, Mugwort, Sage, Lambs Quarter, Kochia, Russian Thistle, Pigweed, Western Waterhemp. She had a grade 1 reaction to the panels containing dog, Epicoccum, Stemphyllium, Monilia, Trichoderma, and Cephalosporium. On skin prick testing, she had a positive skin prick test to Golden Rod (grade 4), Dock (grade 3), Sorrel (grade 3), Dog Fennel (grade 3), dust mite (grade 3), American Cockroach (grade 3), German Cockroach (grade 3). She had no reaction to any of the molds which were included in the intradermal panels during individualized skin prick testing.

[12] Bean-Jeanne Bean-M001067.

[13] Bean-Jeanne Bean-M001065.

[14] Bean Supp. Medical Records00006-00007.

[15] Bean-Jeanne Bean-M001072.

[16] Bean-Jeanne Bean-M001064.

[17] Bean-Jeanne Bean-M000711.

[18] Bean-Jeanne Bean-M000720.

prednisone taper. She was diagnosed with idiopathic anosmia at this visit.[19] On 7/10/09, she was seen by her primary care provider for sinus pressure, ear pressure, dizziness, and nausea. She was treated for sinusitis with biaxin. The documentation noted a previous episode in June that was treated with augmentin.[20] She again saw her primary provider on 11/16/09 for congestion, drainage, facial pressure, cough, fever, and chills. She was treated with azithromycin for bronchitis.[21] She was seen for sinus pain and treated for sinusitis with augmentin on 1/7/10.[22] On 3/13/10, she presented with congestion, sinus pressure, and ear pressure, and diagnosed with sinusitis and treated with azithromycin.[23] She was seen on 6/3/10 for ear pain and sore throat and for not being able to hear well. At that time, she was given azithromycin, Medrol, Sudafed, and Flonase.[24] On 10/2/10, she was treated for acute sinusitis with azithromycin after presenting with sore throat, sinus pain, sneezing, and headache.[25] She was again seen on 2/17/11 in the primary care clinic for sinus pressure, headache, and ear pain and was diagnosed with eustachian tube dysfunction and treated with Flonase.[26] On 4/7/11, she was diagnosed with sinusitis and treated with augmentin and Medrol after presenting with sinus and ear pressure and pain.[27] All of these visits were prior to moving to Mississippi and living in the home related to this Rule 35 examination.

While living in Mississippi, on 1/21/15, she was seen by her primary provider for left ear pain for three days and sinus pressure for approximately three years. She was diagnosed with sinusitis and given a betamethasone injection along with Claritin D and singulair. A CT sinus was ordered at that time.[28] This was done on 1/23/15 and was interpreted by a radiologist to show moderate septal deviation rightward, and a small right maxillary sinus Haller cell with osteomeatal unit narrowing on right.[29] She was again seen on 7/28/15 for sinus pressure, along with other issues, including anxiety and constipation. She was given azithromycin and saline sprays for sinusitis, along with Xanax for anxiety and linzess for constipation.[30] On 10/22/15, she was seen by an ENT in Ocean Springs, MS, and reported symptoms for ten years. She reported congestion, postnasal drainage, cough, headache, sinus pain and pressure, and anosmia. She denied any history of asthma or eczema but reported Meniere's disease and left ear pressure. She was diagnosed with chronic pansinusitis, allergic rhinitis, and a deviated septum. They ordered another CT sinus at that time.[31] This was done on 10/27/15 and had septal deviation to the right,

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[19] Bean-Jeanne Bean-M001081.

[20] Bean-Jeanne Bean-M000125.

[21] Bean-Jeanne Bean-M000123-000124.

[22] Bean-Jeanne Bean-M000112-000113.

[23] Bean-Jeanne Bean-M000114-000115.

[24] Bean-Jeanne Bean-M000122.

[25] Bean-Jeanne Bean-M000116-000117.

[26] Bean-Jeanne Bean-M000120-000121.

[27] Bean-Jeanne Bean-M000118-000119.

[28] Bean Initial Disclosures 000532-000533.

[29] Bean Initial Disclosures 000543-000544.

[30] Bean Initial Disclosures 000435-000436.

[31] Bean-Jeanne Bean-M001024-001026.

and inferior turbinate hypertrophy with Haller cell according to the radiologist's interpretation.[32] During her follow-up visit to discuss the CT sinus with the ENT, he mentioned narrowing of the osteomeatal complex as well as the findings mentioned by the radiologist, and a plan for surgery was made.[33] Although the surgical record was not found in my review of medical records, at a follow-up visit on 11/11/15, it was stated that she had surgery on 11/6/15.[34] She was seen several times for nasal endoscopic debridement after surgery, including on 11/18/15,[35] 11/24/15,[36] 12/8/15,[37] and 12/15/15.[38] After moving back to Tennessee, she was again seen by her primary provider on 3/16/17 for a routine visit and complained of nasal congestion, reflux and nausea, and cough.[39]

At our visit on June 6, 2019, she reported that while living in the home she developed lung problems. She reported that she did not have any lung problems before living in the home, but even after she moved out, the lung problems have continued. She stated that she predominantly had shortness of breath, and she continues to have shortness of breath and chest tightness after moving out. She stated that while living in the home she was on Symbicort routinely but now, only as needed, which is about 1 time per week. She reported having a pulmonary function test (PFT) done while living in the home and that she was told she had possible COPD. She told me that she had smoked off and on for approximately 20 years but was never a heavy smoker, only smoking 2-4 cigarettes per day. She stated that she quit completely 20 years ago. Review of medical records indicate that she presented with cough as far back as a telephone consult visit on 10/8/01.[40] On 3/8/06, she required admission to the hospital for a post-influenza pneumonia.[41] On 4/10/11, while living in Tennessee, she was seen in an urgent care clinic for shortness of breath. At that time, her chest Xray was normal.[42] On 11/16/09, she reported cough, along with rhinitis/sinusitis symptoms, and she was treated with azithromycin for bronchitis.[43] She was admitted to the hospital in May 2016, while in Tennessee, with severe and constant shortness of breath and chest pressure for several days. During this admission, a cardiac evaluation was done, including a treadmill stress test which showed 1mm of ST depression and was called a positive test.[44] This was followed by a myocardial perfusion test, which showed no perfusion defects.[45]

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[32] Bean-Jeanne Bean-M001022-001023.

[33] Bean-Jeanne Bean-M001024-001026.

[34] Bean Initial Disclosures 000028.

[35] Bean Initial Disclosures 000029.

[36] Bean Initial Disclosures 000030.

[37] Bean Initial Disclosures 000031.

[38] Bean Initial Disclosures 000032.

[39] Bean-Jeanne Bean-M000486-000490.

[40] Bean-Jeanne Bean-M001022-001067.

[41] Bean-Jeanne Bean-M00616-000617.

[42] Bean-Jeanne Bean-M000342-000343.

[43] Bean-Jeanne Bean-M000123-000124.

[44] Bean-Jeanne Bean-M000174.

[45] Bean Initial Disclosures000085.

Also, during this admission, she had a chest Xray done, which showed chronic fibrocalcific changes of the lungs but was otherwise normal per the radiologist's interpretation,[46] and a CT with PE protocol, which was negative for pulmonary emboli and was interpreted as normal.[47]She was seen on 5/18/16 by her primary care provider for shortness of breath for two weeks, fatigue, and wheezing. A PFT was ordered, along with Ventolin and Xanax.[48] The PFT was done on 5/27/16 and per the pulmonologist's interpretation, had mild airway obstruction with no reversibility, with a normal FEV1 but a loop contour suggesting mild airway obstruction; lung volumes with moderate overinflation; a mild decrease in DLco. The pulmonologist's interpretation was as follows, "the combination of obstruction and reduced diffusing capacity and overinflation is most consistent with emphysema of at least a mild degree."[49] She was seen on 7/18/16 to discuss the PFT results, but she did not agree with the result showing emphysema. It was noted that she had smoked for >20 years, and she was diagnosed with mild emphysema.[50] An alpha-1-antitrypsin genotype was sent, and this was normal with the MM genotype.[51] After moving back to Tennessee, she was seen at a routine visit to establish care on 9/22/16 and reported dyspnea and other respiratory abnormalities, but that her shortness of breath was better since moving back to Tennessee. She was previously told that she had mild COPD, but she did not believe that diagnosis.[52] She was again seen on 3/16/17 for a routine visit and reported nasal congestion, reflux and nausea, and cough. At this visit, the note reads under the review of systems, "Positive for evaluation of cough 2016--? mild COPD; pt thinks this was due to mold allergy in MS."[53]

She also reported during our medical interview that she has heartburn, weakness/fatigue, joint pain and swelling, although these were not associated with living in the home. She stated, however, that when living in the O'Donnell home, any health problem could have been worsened. Review of medical records indicate she was seen for GERD as far back as a GI visit on 11/8/06, while living in Tennessee.[54] As noted above, she was seen by a GI physician while living in Mississippi in 10/2015.[55] Her EGD revealed chronic gastritis, and her colonoscopy showed sigmoid diverticuli and external hemorrhoids with melanosis coli seen on biopsy.[56] After moving back to Tennessee, she reported continued reflux and nausea on 3/16/17.[57] Regarding weakness and fatigue, there was a mention of fatigue at a visit on 10/19/15, when she was seen

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[46] Bean Initial Disclosures000189.

[47] Bean Initial Disclosures000190.

[48] Bean Initial Disclosures000273.

[49] Bean Initial Disclosures000586-000588.

[50] Bean Initial Disclosures000227-000228.

[51] Bean Initial Disclosures000230.

[52] Bean-Jeanne Bean-M00491-000493.

[53] Bean-Jeanne Bean-M000486-000490.

[54] Bean-Jeanne Bean-M000579-000580.

[55] Bean-Jeanne Bean-M000035-000037.

[56] Bean-Jeanne Bean-M000051-000054.

[57] Bean-Jeanne Bean-M000486-000490.

for depression symptoms for two months, anxiety and worry, and emotional stress and fatigue. She was started on Zoloft at that time.[58] (Bean Initial Disclosures 382-383) Again, fatigue was mentioned on 5/18/16 when she presented with shortness of breath for two weeks, fatigue, and wheezing, and a PFT was ordered, along with Ventolin and Xanax. Different forms of joint pain were mentioned at clinic visits. She was admitted to the hospital while living in Tennessee in January 1998[59] for a lumbar herniated disc with radiculopathy requiring surgery on 1/24/98.[60] She had an urgent care visit on 9/3/09 for neck pain with radiculopathy[61] and in 2011, had several physical therapy visits for cervical issues.[62] On 4/14/17, she was seen in the emergency room for hip pain for one month and diagnosed with sciatica.[63] All of these visits were while living in Tennessee.

**Assessment**

In my opinion, Mrs. Bean reported certain symptoms of rhinitis, including nasal congestion and sneezing. She also reported ocular pruritis. She has been seen by an allergist/immunologist and takes medications for these symptoms. However, Mrs. Bean's symptoms were present well before moving into the home in July 2014. Her issues with these symptoms date as far back as 2001 in the reviewed medical records. She was seen by an allergist while living in Tennessee. Her symptoms also persisted well past moving out of the home in August 2016. She also reported a new onset of headaches while living in the home; however, she was seen for headaches as far back as 2001.

Furthermore, while Mrs. Bean's allergy testing from 2001 did demonstrate sensitivity to molds, she was also allergic to various pollens, dust mites, cockroach, and cat dander. One cannot say to a reasonable degree of medical certainty that her symptoms were related to mold exposure, as there are other allergens to consider. Dust mite prevalence is also increased in areas of higher humidity, like the Mississippi Gulf Coast, although dust mites are not visible to the naked eye. They had carpet in the upstairs of the home, which increases exposure to dust mites. Again, she was allergic to numerous aeroallergens, including dust mites, as well as cockroach; tree, grass, and weed pollens; and pet dander. Also, outdoor pollens can be brought inside the home as well, particularly during peak pollen seasons, essentially creating indoor exposures as well. Also, there was no test done in the home to demonstrate what, if any mold, was present inside the home, or if any mold that may have been present in the home are ones that Mrs. Bean is sensitized to. As there was no testing, there is no information demonstrating the molds that were present outdoors as compared to any that may have been indoors. Typically, people are exposed to mold on a routine basis, as molds are ubiquitous in nature and would have been present right outside the O'Donnell home. Her multiple sensitivities on allergy testing further supports that one cannot

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[58] Bean Initial Disclosures000273-000274.

[59] Bean-Jeanne Bean-M000899.

[60] Bean-Jeanne Bean-M000910-000911.

[61] Bean-Jeanne Bean-M000460-000468.

[62] Bean-Jeanne Bean-M000318-000334.

[63] Bean-Jeanne Bean-M000155-000165.

say with any degree of medical certainty that her symptoms were a result of mold exposure in the O'Donnell home.

Mrs. Bean also reported lung problems developing after she moved into the home. She reported these issues as new while living in the home. However, she had complained of cough as far back as 2001 and shortness of breath as far back as 2011, well before moving into the O'Donnell home in June 2014. When she was seen, while living in Mississippi, for shortness of breath and wheeze, she had a PFT ordered. This PFT was interpreted by a pulmonologist as being consistent with mild emphysema. She had been a smoker for >20 years, and this finding is consistent with this type of smoking history. In short, there is no way to say to a reasonable degree of medical certainty that her pulmonary symptoms were related to mold exposure in her home while living in Mississippi, as her PFT was consistent with damage done by her years of smoking. Therefore, in my opinion, to a reasonable degree of medical certainty, these symptoms were not caused by exposure to mold in the Keesler home.

Furthermore, there is no link between mold allergen sensitivities and GERD. Her EGD demonstrated chronic gastritis, and there is no medical link between chronic gastritis and mold allergy. Likewise, there is no link between mold allergen sensitivities and joint pain or swelling. In my opinion, these conditions were not caused or worsened in any way due to mold sensitivity.

In conclusion, to a reasonable degree of medical certainty, none of Jeanne Bean's medical issues were caused or worsened by exposure to mold in her O'Donnell home. In addition, I do not believe any of Mrs. Bean's prior or ongoing medical treatments are attributable to mold exposure in her Keesler Air Force Base home.

All of the opinions that I express in this report are held to a reasonable degree of medical certainty. The opinions are based on medical records and materials I reviewed regarding Mrs. Bean, as well as a clinical interview and exam that I conducted with Mrs. Bean personally. The opinions are also based on my education, training, and experience.

Attached to this report is a medical summary of our clinic visit, as well as the findings on my physical exam. This is Exhibit 2. Attached as Exhibit 3 is her initial skin testing done in 2001.[64] Repeat testing done in August 2005 is attached as Exhibit 4.[65] The MRI brain from 12/2005 is attached as Exhibit 5.[66] The CT sinus from 1/2015 is attached as Exhibit 5[67] and from 10/2015 as Exhibit 6.[68] The CT PE protocol obtained during her hospital admission in May 2016 is attached as Exhibit 7.[69] Finally, her PFT is attached as Exhibit 8.[70]

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[64] Bean-Jeanne Bean-M001073

[65] Bean-Jeanne Bean-M001072.

[66] Bean-Jeanne Bean-M000720.

[67] Bean Initial Disclosures 000543-000544.

[68] Bean-Jeanne Bean-M001022-001023.

[69] Bean Initial Disclosures000190.

[70] Bean Initial Disclosures000586-000588.

I reserve the right to amend this report upon receipt of additional information.

Chelle P. Wilhelm, M.D.

# Curriculum Vitae


## Chelle P. Wilhelm, M.D.

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chellepwilhelm@gmail.com


**Employment:**

Mississippi Asthma and Allergy Clinic, P.A. 2017-current
1513 Lakeland Drive, Suite 101
Jackson, MS 39216
601-354-4836

University of Mississippi Medical Center 2015-2017
Assistant Professor of Medicine and Pediatrics
Department of Medicine
Division of Clinical Immunology and Allergy
601-815-1078

**Language Proficiency:** English

**Education:**

| | |
|---|---|
| 2003-2007 | Doctor of Medicine<br>University of Mississippi Medical Center School of Medicine<br>Jackson, MS |
| 1999-2003 | B.S. Microbiology, *Summa Cum Laude*<br>Mississippi State University<br>Starkville, MS |

**Post-Doctoral Training:**

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|---|---|
| 2013-2015 | Clinical Immunology and Allergy Fellowship<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2011-2013 | Pulmonary Medicine Fellowship<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2010-2011 | Chief Internal Medicine Resident<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2007-2010 | Internal Medicine Internship and Residency<br>University of Mississippi Medical Center<br>Jackson, MS |

**Licensure:**

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|---|---|
| 2016 | American Board of Allergy and Immunology<br>Recertify: 2026 |
| 2013 | American Board of Pulmonary Medicine<br>Recertify: 2023 |
| 2010 | American Board of Internal Medicine<br>Recertify: 2020 |
| 2009 | Mississippi State Medical Licensure- Expires 6/30/19 |

**Recognitions/Honors/Awards:**

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|---|---|
| 2007 | James E. Griffith Pulmonary Award |
| 2000-2001 | Mississippi State University Honors Award |
| 1999-2003 | Mississippi State University President's Scholar |

**Other Professional Appointments and Activities:**

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|---|---|
| 2013-2014 | American College of Physicians Fellowship Council<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2013-2014 | Introduction to Clinical Medicine Preceptor- second year medical students<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2009-2011 | Introduction to Clinical Medicine Preceptor- second year medical students<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2009 | Co-Leader of Introduction to Clinical Medicine "Fridays at the Bedside" for introduction of second year medical students to patient care<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2009 | Residency Improvement Council<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2007-2011 | American College of Physicians Resident Council<br>University of Mississippi Center<br>Jackson, MS |

**Professional Committees:**

| | |
|---|---|
| 2016-2017 | Ethics Advisory Committee<br>Chaired by: Kathy Gregg, MD<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2015-2016 | Program Evaluation Committee- Allergy/Immunology Program<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2011-2015 | Resident Review Committee<br>University of Mississippi Medical Center |

Jackson, MS

**Society Memberships:**

| | |
|---|---|
| 2015-current | Mississippi Society of Asthma, Allergy, and Immunology |
| 2015-current | Mississippi State Medical Association (MSMA) |
| 2013-current | American College of Allergy, Asthma, and Immunology (ACAAI) |
| 2013-current | American Academy of Allergy, Asthma, and Immunology (AAAAI) |
| 2010-current | American College of Chest Physicians (ACCP) |
| 2010-2016 | American Thoracic Society (ATS) |

**Clinical Research:**

| | |
|---|---|
| 2013-2017 | A Randomized, Double-blind, Placebo-controlled Study to Evaluate the Safety and Efficacy of Brodalumab in Subjects with Inadequately Controlled Asthma and High Bronchodilator Reversibility. Amgen. Sub-investigator; Primary investigator- Dr. Gailen Marshall. |
| 2013-2017 | A 26 Week, Randomized, Double-blind, Parallel-group, Active Controlled, Multicenter, Multinational Safety Study Evaluating the Risk of Serious Asthma-related Events During Treatment with Symbicort, a Fixed Combination of Inhaled Corticosteroids (ICS) (Budesonide) and a Long Acting Beta-agonist (LABA) (Formoterol) as Compared to Treatment with ICS (Budesonide) Alone in Adult and Adolescent (>12 years of Age) Patients with Asthma. AstraZeneca. Sub-investigator; Primary investigator- Dr. Gailen Marshall |

**External Peer Reviewer of Evidence-Based Medicine:**

2015-current Reviewer for *Annals of Allergy, Asthma, and Immunology*

**Publications:**

Peer-Reviewed

Wilhelm CP, Chipps BE. Bronchial Thermoplasty: A Review of the Evidence. Ann Allergy Asthma Immunol. 2016;116:92-98.

Wilhelm CP, deShazo RD, Tamanna S, Ullah MI, Skipworth LB. The Nose, Upper Airway, and Obstructive Sleep Apnea. Ann Allergy Asthma Immunol. 2015;115(2):96-102.

Pope CR, Wilhelm AM, Marshall GD. Psychological Stress Interventions and Asthma: Therapeutic Considerations. JCOM. 2014;21:570-76.

Tamanna S, Ullah MI, Pope CR, Holloman G, Koch CA. Quetiapine-induced Sleep-related Eating Disorder-like Behavior. A Case Series. J Med Case Rep. 2012;6:380.

Book Chapter

Pope CR, deShazo RD. "Age- Co-Morbid and Co-Existing." *Asthma, Comorbidities, Co-Existing Conditions, and Differential Diagnosis.* Oxford University Press; 2014.

**Abstracts/Presentations:**

Pulmonary Infiltrates with Eosinophilia in a 7-Week Old Infant. Pope CR, Hall AG, Dave N, Yates AB. Poster presentation at American College of Allergy, Asthma, and Immunology Annual Meeting. Baltimore, MD 2013

A Case of Excessive Kerley Lines. Oral Presentation of patient with Erdheim Chester Disease. Tri-State Pulmonary Conference. New Orleans, LA 2012.

**University Teaching Conferences:**

Allergic Bronchopulmonary Aspergillosis for Pulmonary Fellows- April 12, 2017

Interstitial Lung Disease for Allergy/Immunology Fellows- March 17, 2017

Asthma Guidelines for Internal Medicine Residents- August 18, 2016

Rhinoscopy Instruction and Demonstration for Allergy/Immunology Faculty, Fellows, and Nursing staff- June 10, 2016

Wegener Granulomatosis for Allergy/Immunology Fellows- May 20, 2016

Pulmonary Function Testing Interpretation for Allergy/Immunology Fellows- January 29, 2016; August 25, 2016

Chronic Obstructive Pulmonary Disease (COPD) for Allergy/Immunology Fellows- November 13, 2015

Asthma Guidelines for Family Medicine Residents- December 3, 2015

**Regional Teaching Conferences:**

Assessment, Diagnosis, and Monitoring for Asthma- American Lung Association Asthma Educators Institute- Jackson, MS, April 19, 2017

Asthma Update for Primary Care Physician- Hazelhurst, MS, October 17, 2016

**Community Activities:**

American Lung Association, Board Member 2017- current

# History and Physical

| | | | |
|---|---|---|---|
| **Patient Name:** | Jeanne Bean | **Create Date:** | June 30, 2019 |
| **Patient ID:** | 327547 | | |
| **Sex:** | Female | | |
| **Birthdate:** | [redacted] | | |

## Chief Complaint

Rule 35 Examination

## History Of Present Illness

Patient presents for the Rule 35 examination.

She brought with her her previous allergy notes and skin testing. These were the same that were in the provided medical records and had already been reviewed.

She reported that she has a PMH of Graves disease, now with hypothyroidism after thyroidectomy. She takes a thyroid pill for this. Also, she has HTN and takes 2 blood pressure pills, but she was not sure what these were. She also reported GERD and takes nexium for this. She also is on a cholesterol pill.

She reported nasal congestion, sneezing, and itching of the eyes and some vision loss. She reported that her symptoms are year round. She stated that these symptoms had improved slightly since she had sinus surgery in 2015. She reported that she does not have a sense of smell and her sense of taste is also decreased. She stated that all of these symptoms worsened while she was living in the home related to this Rule 35 examination, and they decreased after they moved out of the home (back to her baseline). She stated that she is taking singulair and flonase daily and using antihistamines only PRN. She also reported that she developed headaches while living in the home, and she really did not have this issue prior. She reported that she was allergy tested and was positive to numerous things. She stated that the testing was in the records she gave to me at the visit.

She reported that she did not have any lung problems prior to living in the home, but while living there, she developed issues with SOB. She stated that she still has SOB and tightness in her chest despite moving out. She reported that she had a PFT done while in the home, and this showed possible COPD. She was on symbicort routinely while living in the home, but since moving out, only uses it PRN, which is about 1 time/week.

She also reported that she has heartburn, weakness/fatigue, joint swelling and pain, although these were not associated with living in the home. She stated, however, that really when living in that situation, any health problem could have been worsened.

She smoked off and on for about 20 years, about 2-4 cigarettes/day. She reported that she quit 20 years ago. She drinks wine or beer occasionally. She reported that they do have a poodle in the home and had it while living in the home related to this Rule 35 examination. This home did have carpeting upstairs. The home they live in now only has carpet in the bedrooms.

## Past Medical History

| Disease Name | Date Onset | Notes |
|---|---|---|
| GERD | -- | -- |
| Hypertension | -- | -- |
| Thyroid disease | -- | -- |

## Past Surgical History

| Procedure Name | Date | Notes |
|---|---|---|
| Back surgery | -- | -- |
| Cholecystectomy | -- | -- |
| Colon surgery | -- | -- |

| | | |
|---|---|---|
| Sinus Surgery | -- | -- |
| Thyroidectomy | -- | -- |

## Medication List

Reviewed None Changed

## Allergy List

| Allergen Name | Date | Reaction | Notes |
|---|---|---|---|
| NO KNOWN DRUG ALLERGIES | -- | -- | -- |
| No Known Food Allergies | -- | -- | -- |

## Family Medical History

Reviewed None Changed

## Social History

| Finding | Status | Start/Stop | Quantity | Notes |
|---|---|---|---|---|
| Alcohol | -- | --/-- | -- | occasional wine or beer |
| Carpet | -- | --/-- | -- | -- |
| Former smoker | -- | --/-- | -- | quit about 20 years ago, smoked off and on for 20 years, approx 2-4 cig/day |
| Indoor Pets | -- | --/-- | -- | -- |

## Review of Systems

**Constitutional**
- **Denies** : fever, night sweats

**Eyes**
- **Admits** : See HPI

**HENT**
- **Admits** : See HPI

**Breasts**
- **Denies** : tenderness

**Cardiovascular**
- **Denies** : chest pain, tachycardia, irregular heart beats

**Respiratory**
- **Admits** : See HPI

**Gastrointestinal**
- **Admits** : See HPI

**Genitourinary**
- **Denies** : urinary retention, dysuria, frequency

**Integument**
- **Denies** : rash, eczema

**Neurologic**
- **Denies** : headaches, migraine headaches

**Musculoskeletal**
- **Admits** : See HPI

**Endocrine**
- **Denies** : inappropriate weight gain, inappropriate weight loss

**Psychiatric**
- **Denies** : anxiety, depression

**Heme-Lymph**
- **Denies** : lymph node enlargement or tenderness, recurrent fevers, easy bleeding, easy bruising

**Allergic-Immunologic**
- **Denies** : recurrent infections, unusual infections

**All Others Negative**

## Vitals

| Date | Time | BP | Position | Site | L/R | Cuff Size | HR | RR | TEMP (F) | WT | HT | BMI kg/m² | BSA m² | O2 Sat |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 06/30/2019 | 02:50 PM | 131/84 | Sitting | | | | 67 - R | | 98.5 | 132lbs 0oz | 5' 2" | 24.14 | 1.62 | 100 % |

## Physical Examination

**Constitutional**
- **Appearance** : well nourished, alert, in no acute distress

**Eyes**
- **Conj, Sclera, Lids** : conjunctiva normal, sclera white without injection, eyelid appearance normal
- **Pupils and Irises** : pupils equal, round, reactive to light

**HENT**
- **Head** : normocephalic
- **Ears - External** : external ears within normal limits
- **Ears - Otoscopic** : tympanic membranes intact without erythema, external auditory canals clear
- **Ears - Hearing** : hearing intact bilaterally
- **Nose** : external nose normal appearance, nares patent, nasal mucosa pink, septum midline, turbinates benign and no masses; no drainage
- **Mouth and Lips** : oral mucosa pink and moist, lip appearance normal
- **Oropharynx** : oropharynx clear without erythema or exudates, tonsils benign

**Neck**
- **Neck** : normal size

**Chest**
- **Respiratory Effort** : breathing unlabored, no retractions or accessory muscle use
- **Auscultation** : breath sounds clear bilaterally

**Cardiovascular**
- **Auscultation** : regular rate, normal rhythm, no murmurs present
- **Peripheral circulation** : without edema, cyanosis

**Psychiatric**
- **Judgement, insight** : judgement and insight intact
- **Orientation** : oriented to person,place and time
- **Mood and affect** : normal affect

**Musculoskeletal**
- **Digits and Nails** : no clubbing, cyanosis, deformities or edema present, normal appearing nails, no deformities present

**Skin**
- **Inspection** : no rashes present, no lesions present
- **Palpation** : no palpable rashes

**Electronically Signed by:** Chelle Wilhelm, MD -Author on July 5, 2019 01:43:53 PM

☐ Robert M. Overholt, M.D.
☐ Michael A. Springer, M.D.

# The Allergy, Asthma, and Sinus Center
## Inhalant Skin Test Form

☒ Ty L. Prince, M.D.
☐ R. David Ponder, M.D.
☐ David L. Gossage, M.D.

Patient Name Jeanne Bean  Chart # 83009  Date 9-12-01

Epicutaneous # 72  Intracutaneous # 16  Skin Test Device Duotip  Nrs. Int. 1/1

| | | Epicutaneous wheal | Epicutaneous flare | Epicutaneous grade | Intracutaneous wheal | Intracutaneous flare | Intracutaneous grade |
|---|---|---|---|---|---|---|---|
| A | 1. Saline | | | 0 | | | |
| | 2. Histamine | 5 | 15 | 4+ | | | |
| B | 1. Elm | | | 0 | | | T1 |
| | 2. Hackberry | | | 0 | | | |
| | 3. Mulberry | | | 0 | | | |
| | 4. Willow | | | 0 | | | |
| | 5. Poplar | | | 0 | | | |
| C | 1. Birch | | | 0 | | | T2 |
| | 2. Tag Alder | | | 0 | | | |
| | 3. Oak (Mix) | | | 0 | | | |
| | 4. Hazelnut | | | 0 | | | |
| | 5. Beech | | | 0 | | | |
| D | 1. Pecan | | | 0 | | | T3 |
| | 2. Hickory | | | 0 | | | |
| | 3. Walnut | | | 0 | | | |
| | 4. Cedar | | | 0 | | | |
| | 5. Pine | | | 0 | | | |
| E | 1. Sycamore | | | 0 | | | T4 |
| | 2. Ash | | | 0 | | | |
| | 3. Privet | | | 0 | | | |
| | 4. Maple | | | 0 | | | |
| | 5. Box Elder | | | 0 | | | |
| F | 1. Bermuda | | | 0 | | | Gr |
| | 2. Johnson | | | 0 | | | |
| | 3. Kentucky Blue | | | 0 | | | |
| | 4. Meadow Fescue | | | 0 | | | |
| | 5. Orchard | | | 0 | | | |
| G | 1. Perennial Rye | | | 0 | | | |
| | 2. Redtop | | | 0 | | | |
| | 3. Sweet Vernal | | | 0 | | | |
| | 4. Timothy | | | 0 | | | |
| H | 1. Ragweed Mix | | | 0 | | | W1 |
| | 2. Marshelder | | | 0 | | | |
| | 3. Cocklebur | | | 0 | | | |
| | 4. Wormwood | | | 0 | | | |
| | 5. Mugwort Sage | | | 0 | | | |
| I | 1. Lambs Quarter | | | 0 | | | W2 |
| | 2. Kochia | | | 0 | | | |
| | 3. Russian Thistle | | | 0 | | | |
| | 4. Pigweed | | | 0 | | | |
| | 5. Western Waterhemp | | | 0 | | | |
| J | 1. Plaintain | | | 0 | | | W3 |
| | 2. Golden Rod | 5 | 15 | 4+ | | | |
| | 3. Dock | 3 | 15 | 3+ | | | |
| | 4. Sorrel | 5 | 15 | 4+ | | | |
| | 5. Dog Fennel | 5 | 15 | 4+ | | | |
| K | 1. D. f. (Dust Mite) | | | 0 | | | D.f. |
| | 2. D. p. (Dust Mite) | 3 | 15 | 3+ | | | D.p. |
| | 3. Amer. Cockroach | 3 | 10 | 3+ | | | A. Cr. |
| | 4. German Cockroach | 3 | 10 | 3+ | | | G. Cr. |
| | 5. Cat | | | 0 | | | Cat |
| | 6. Dog | | | 0 | | | Dog |
| L | 1. Alternaria | | | 0 | | | M1 |
| | 2. Helminthosporium | | | 0 | | | |
| | 3. Cladosporium | | | 0 | | | |
| | 4. Aspergillus | | | 0 | | | |
| | 5. Penicillium | | | 0 | | | |
| M | 1. Fusarium | | | 0 | | | M2 |
| | 2. Rhizopus | | | 0 | | | |
| | 3. Curvularia | | | 0 | | | |
| | 4. Pullularia | | | 0 | | | |
| | 5. Mucor | | | 0 | | | |
| N | 1. Epicoccum | | | 0 | | | M3 |
| | 2. Stemphylium | | | 0 | | | |
| | 3. Monilia | | | 0 | | | |
| | 4. Trichoderma | | | 0 | | | |
| | 5. Cephalosporium | | | 0 | | | |
| O | 1. Chaetomium | | | 0 | | | M4 |
| | 2. Botrytis | | | 0 | | | |
| | 3. Geotrichum | | | 0 | | | |
| | 4. Rhodotorula | | | 0 | | | |
| | 5. Phoma | | | 0 | | | |
| Miscellaneous | | | | | | | |

**Key:**
Testing material from Greer Labs
Test interpreted by either of below methods:
1. wheal diameter (mm) / erythemia diameter (mm)
2. semiquantitative skin test grading system as indicated

**Criteria for Epicutaneous**

| | | |
|---|---|---|
| 0 | reaction no different from glycerosaline | |
| 1+ | wheal < 3mm | erythemia < 21mm |
| 2+ | wheal > 3mm | erythemia ≥ 21mm |
| 3+ | wheal ≥ 3mm | any erythemia |
| 4+ | wheal with pseudopods | any erythemia |

**Criteria for Intracutaneous**

| | | |
|---|---|---|
| 0 | reaction no different from glycerosaline | |
| 1+ | wheal < 5mm | erythemia < 10mm |
| 2+ | wheal 5-10mm | erythemia ≥ 10mm |
| 3+ | wheal 11-15mm | erythemia ≥ 20mm |
| 4+ | wheal ≥ 15mm or any pseudopods | erythemia ≥ 30mm |

Form #IST
Revised 4/26/00

☐ Robert M. Overholt, M.D.
☐ Michael A. Springer, M.D.
☐ J.D. Fleenor, M.D.

# The Allergy, Asthma, and Sinus Center
## Inhalant Skin Test Form

Ty L. Prince, M.D. ☒
R. David Ponder, M.D. ☐
David L. Gossage, M.D. ☐
Paul M. Carter, M.D. ☐

Patient Name Jeanne Bean  Chart # 83009  Date 8/25/05

Epicutaneous # 72  Intracutaneous #  Skin Test Device Greer  Nrs. Int. JH

| | | Epicutaneous wheal | Epicutaneous flare | Epicutaneous grade | Intracutaneous wheal | Intracutaneous flare | Intracutaneous grade |
|---|---|---|---|---|---|---|---|
| A | 1. Saline | | | 0 | | | |
| | 2. Histamine | | | III | | | |
| B | 1. Elm | | | 0 | | | T1 |
| | 2. Hackberry | | | 0 | | | |
| | 3. Mulberry | | | 0 | | | |
| | 4. Willow | | | 0 | | | |
| | 5. Poplar | | | 0 | | | |
| C | 1. Birch | | | 0 | | | T2 |
| | 2. Tag Alder | | | 0 | | | |
| | 3. Oak (Mix) | | | 0 | | | |
| | 4. Hazelnut | | | 0 | | | |
| | 5. Beech | | | 0 | | | |
| D | 1. Pecan | | | 0 | | | T3 |
| | 2. Hickory | | | 0 | | | |
| | 3. Walnut | | | 0 | | | |
| | 4. Cedar | | | 0 | | | |
| | 5. Pine | | | 0 | | | |
| E | 1. Sycamore | | | 0 | | | T4 |
| | 2. Ash | | | 0 | | | |
| | 3. Privet | | | 0 | | | |
| | 4. Maple | | | 0 | | | |
| | 5. Box Elder | | | I | | | |
| F | 1. Bermuda | | | 0 | | | Gr |
| | 2. Johnson | | | 0 | | | |
| | 3. Kentucky Blue | | | 0 | | | |
| | 4. Meadow Fescue | | | 0 | | | |
| | 5. Orchard | | | 0 | | | |
| G | 1. Perennial Rye | | | 0 | | | |
| | 2. Redtop | | | 0 | | | |
| | 3. Sweet Vernal | | | 0 | | | |
| | 4. Timothy | | | 0 | | | |
| H | 1. Ragweed Mix | | | 0 | | | W1 |
| | 2. Marshelder | | | 0 | | | |
| | 3. Cocklebur | | | 0 | | | |
| | 4. Wormwood | | | 0 | | | |
| | 5. Mugwort Sage | | | 0 | | | |
| I | 1. Lambs Quarter | | | 0 | | | W2 |
| | 2. Kochia | | | 0 | | | |
| | 3. Russian Thistle | | | 0 | | | |
| | 4. Pigweed | | | 0 | | | |
| | 5. Western Waterhemp | | | 0 | | | |
| J | 1. Plaintain | | | 0 | | | W3 |
| | 2. Golden Rod | | | 0 | | | |
| | 3. Dock | | | 0 | | | |
| | 4. Sorrel | | | 0 | | | |
| | 5. Dog Fennel | | | 0 | | | |
| K | 1. D. f. (Dust Mite) | | | 0 | | | D.f. |
| | 2. D. p. (Dust Mite) | | | 0 | | | D.p. |
| | 3. Amer. Cockroach | | | 0 | | | A. Cr. |
| | 4. German Cockroach | | | 0 | | | G. Cr. |
| | 5. Cat | | | 0 | | | Cat |
| | 6. Dog | | | 0 | | | Dog |
| L | 1. Alternaria | | | 0 | | | M1 |
| | 2. Helminthosporium | | | 0 | | | |
| | 3. Cladosporium | | | 0 | | | |
| | 4. Aspergillus | | | 0 | | | |
| | 5. Penicillium | | | 0 | | | |
| M | 1. Fusarium | | | 0 | | | M2 |
| | 2. Rhizopus | | | 0 | | | |
| | 3. Curvularia | | | 0 | | | |
| | 4. Pullularia | | | 0 | | | |
| | 5. Mucor | | | 0 | | | |
| N | 1. Epicoccum | | | 0 | | | M3 |
| | 2. Stemphylium | | | 0 | | | |
| | 3. Monilia | | | 0 | | | |
| | 4. Trichoderma | | | 0 | | | |
| | 5. Cephalosporium | | | 0 | | | |
| O | 1. Chaetomium | | | 0 | | | M4 |
| | 2. Botrytis | | | 0 | | | |
| | 3. Geotrichum | | | 0 | | | |
| | 4. Rhodotorula | | | 0 | | | |
| | 5. Phoma | | | 0 | | | |
| Miscellaneous | | | | 0 | | | |

Histamine

**Key:**
Testing material from Greer Labs
Test interpreted by either of below methods:
1. wheal diameter (mm) / erythema diameter (mm)
2. semiquantitative skin test grading system as indicated

**Criteria for Epicutaneous**

| | | |
|---|---|---|
| 0 | reaction no different from glycerosaline | |
| 1+ | wheal < 3mm | erythema < 21mm |
| 2+ | wheal < 3mm | erythema ≥ 21mm |
| 3+ | wheal ≥ 3mm | any erythema |
| 4+ | wheal with pseudopods any erythema | |

**Criteria for Intracutaneous**

| | | |
|---|---|---|
| 0 | reaction no different from glycerosaline | |
| 1+ | wheal < 5mm | erythema < 10mm |
| 2+ | wheal 5-10mm | erythema ≥ 10mm |
| 3+ | wheal 11-15mm | erythema ≥ 20mm |
| 4+ | wheal ≥ 15mm or any pseudopods | erythema ≥ 30mm |

Form #IST
Revised 10/28/01

The University of Tennessee Memorial Hospital
1924 Alcoa Hwy. Knoxville, TN 37920
(865) 544-9060
Radiology Consultation Report

BEAN, JEANNE F
MR.: 0349299
Location: OP MR SCAN
Sex: Female
Age: 45 years
Attending Dr.: Overholt (Otolaryngology), Samuel M
Account #: 03492990009

Consulting Dr.: N/A
Accession #: MI-05-0016281

| Radiology Report: | | Ordering MD: |
|---|---|---|
| MRI Brain & Stem With & Without Contrast | 12/07/05 14:00:00 | Overholt (Otolaryngology), Samuel M |

Results
Indication: Loss of smell.

Technique: Contrast MR brain using skullbase protocol.

Findings: No abnormal contrast enhancement or masses are identified. No mass-effect or midline shift. The metacarpal white matter, ventricles, and cisterns are normal. Diffusion weighted images are normal. Physiologic flow-voids are grossly unremarkable. Craniocervical junction is normal. Paranasal sinuses and mastoid air cells are clear.

Impression:

No abnormalities identified.

Authenticated By: JACOB, PRADEEP K 12/08/2005 1:52 pm
Resident: Smith, (Resident) Catherine M

**FINAL REPORT** This exam and report have been reviewed by an attending physician.**



PRINTED BY: CHACKLER
DATE 2/18/2019

* Auth (Verified) *

CT Sinus w/o Contrast

Bean, Jeanne Faye - 0000700630

* Final Report *

## * Final Report *

**Reason For Exam**
Sinusitis, acute

**Report**
CT SINUS WITHOUT CONTRAST, 1/23/2015 8:44 AM:

CLINICAL INFORMATION: Sinusitis. Ear infection.

COMPARISON: None

FINDINGS:

Moderate severity nonuniform nasal septal deviation predominantly rightward. No paranasal sinus fluid or appreciable mucosal thickening. No abnormal turbulent pneumatization. Small right maxillary sinus Haller cell with narrowing of the right infundibulum of the ostiomeatal unit. Multiple dental implants are noted in the maxilla. Globes and bony orbits are symmetric.

IMPRESSION:

MODERATE SEVERITY NONUNIFORM NASAL SEPTAL DEVIATION.

RIGHT MAXILLARY SINUS HILAR CELL WITH RIGHT OSTIOMEATAL UNIT INFUNDIBULAR NARROWING.

**Signature Line**
***** Final *****

Dictated by: Lawson, Eric D MD
Dictated DT/TM: 01/23/2015 8:55 am
Signed by: Lawson, Eric D MD

| | |
|---|---|
| Result type: | CT Sinus w/o Contrast |
| Result date: | January 23, 2015 08:55 CST |
| Result status: | Auth (Verified) |
| Result title: | CT Sinus w/o Contrast |
| Performed by: | Lawson, Eric D MD on January 23, 2015 08:55 CST |
| Verified by: | Lawson, Eric D MD on January 23, 2015 11:14 CST |
| Encounter info: | 2000541722, DC at Cedar Lak, Outpatient, 01/23/15 - 01/23/15 |

Printed by: Stokes, Angela A LPN
Printed on: 01/27/15 14:26 CST

* Auth (Verified) *

## CT Sinus w/o Contrast

Bean, Jeanne Faye - 0000700630

* Final Report *

Signed (Electronic Signature): 01/23/2015 11:14 am

**Report**
This document has an image

**Completed Action List:**
* Order by Thomas, Carricka NP on January 21, 2015 14:30 CST
* Perform by Callaway, Janice on January 23, 2015 08:55 CST
* VERIFY by Lawson, Eric D MD on January 23, 2015 11:14 CSTRequested on January 23, 2015 09:19 CST
* Endorse by Thomas, Carricka NP on January 27, 2015 08:13 CST

| | |
|---|---|
| Result type: | CT Sinus w/o Contrast |
| Result date: | January 23, 2015 08:55 CST |
| Result status: | Auth (Verified) |
| Result title: | CT Sinus w/o Contrast |
| Performed by: | Lawson, Eric D MD on January 23, 2015 08:55 CST |
| Verified by: | Lawson, Eric D MD on January 23, 2015 11:14 CST |
| Encounter info: | 2000541722, DC at Cedar Lak, Outpatient, 01/23/15 - 01/23/15 |

Printed by: Stokes, Angela A LPN
Printed on: 01/27/15 14:26 CST


(End of Report)

Bay Area ENT, PLLC
1137 Ocean Springs Road
1720A Medical Park Drive, Ste 100
Biloxi, MS 39532
Phone: 228-392-9090, 228-875-8291
Fax: 877-504-3044

CT ROUTINE SINUS

Patient ID: 41787-1-BAENT
Patient: JEANNE BEAN
DOB: [redacted]
Gender: F
Date of examination: 10/27/2015
History: Chronic Sinusitis

Comparison: NONE

Technique: Images acquired utilizing Carestrem CS9300 cone beam computed tomography. Images reformatted using the eFilm workstation.

Findings:

Septum/Nasal Cavity
Septal deviation to the right. Nasal septum without obvious perforation.
Turbinates
Middle turbinates without concha bullosa. Middle turbinates without paradoxical curvature. Middle turbinates without evidence of previous surgery. Bilateral inferior turbinates with hypertrophy. Inferior turbinates without evidence of previous surgery.
Osteomeatal Complexes
Bilateral osteomeatal complex do not appear compromised. No defect in medial maxillary wall is noted. Haller cell.
Maxillary Sinuses
Maxillary sinus without mucosal thickening.
Frontal Sinuses
Frontal sinuses without mucosal thickening. Bilateral frontal sinus outflow tracts are normal.
Ethmoid Sinus Complex
Bilateral anterior ethmoid cells without mucosal thickening. Posterior ethmoid cells without mucosal thickening.

1137 Ocean Springs Road
1720A Medical Park Drive, Ste 100
Biloxi, MS 39532
Phone: 228-392-9090, 228-875-8291
Fax: 877-504-3044

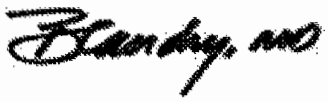
JEANNE BEAN 10/27/2015

Sphenoid Sinuses
Sphenoid sinuses without mucosal thickening.
Fovea Ethmoidalis
Fovea ethmoidalis in normal position.

IMPRESSION:

Septal deviation to the right, inferior turbinate hypertrophy and Haller cell.

Thank you for the opportunity to assist you in the evaluation of your patient. Your expression of confidence is sincerely appreciated.



Bernard A. Landry, MD, FACR
Electronically verified: 10/30/2015 07:23

BLOUNT MEMORIAL HOSPITAL
MARYVILLE, TN

RADIOLOGY REPORT

MR#: 000452493
NAME: BEAN, JEANNE
Location: 4S0426D
Ordering Provider: THOMPSON, HEATHER
ACCESSION#: 1560406
EXAM: CTPESTUDY - CT PE STUDY WITH RECONSTRUCTION
EXAM DATE: 5/13/2016

Account#: 8898741
DOB: [redacted]
Admit Date: 5/13/2016

ORDER#: 00157668126

---

REASON FOR EXAM: shortness of breath-

COMPARISON: None.

Axial images performed after 75 cc Optiray-320 in pulmonary arterial phase. Exam performed in expiration to maximize pulmonary artery opacification. This limits evaluation for lung nodules.

PE PROTOCOL: Multiplanar and three-dimensional reformatted images were performed of these.

DOSE REDUCTION TECHNIQUES: Iterative reconstruction and Automated exposure control.

PULMONARY VESSELS: No vessel cut off or filling defects. Normal distribution.

THORACIC AORTA: Normal caliber, no aneurysm or obvious dissection.

LUNGS: No pneumonia or suspicious nodule. No pleural effusion..

HEART: Normal in size. No pericardial effusion.

MEDIASTINUM AND HILA: No adenopathy or mass.

IMPRESSION: No evidence of pulmonary embolus.

Dictated on: 5/13/2016 5:26 PM
Interpreted by: John Niethammer, M.D.
Transcribed by: Powerscribe 360
Signed by: John Niethammer, M.D.

Approved Date: 05/13/2016 05:26 PM

Patient Name: Bean, Jeanne Faye
Date of Birth: 2/13/1960

MRN: 0000700630
FIN: 2001713696

* Auth (Verified) *

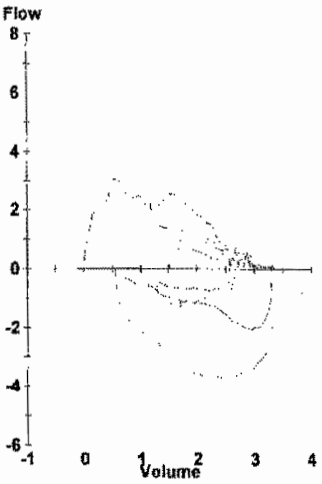
Memorial

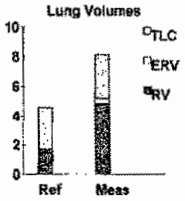
***Memorial Hospital at Gulfport***
***4500 13th Street***
***Gulfport, MS 39502***

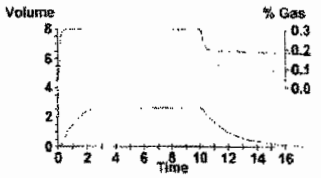
**Date: 05/27/16**
**Name: Bean, Jeanne Faye**
**ID: 700630** **FIN: 2001713696**
Age: 56 Height(in): 62.2
Weight(lb): 152 Gender: Female
Race: Caucasian
**Technician: Mary Everett, CRT**
**Physician: Carricka Thomas NP**

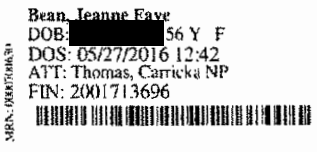
**Diagnosis: Shortness of Breath**
Dyspnea Rest: No Dyspnea Exercise: No
Cough: No Persistent: No Productive (cc):
Smoker: Yes Cigarettes: Yes Cigars: No Pipe: No
How Long: 30 Quit: Yes Stopped: 16

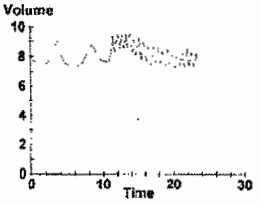
| | | | Ref | Pre | % Ref | Post | % Ref | %Chg |
|---|---|---|---|---|---|---|---|---|
| Spirometry | | | | | | | | |
| | FVC | Liters | 2.87 | 3.32 | 115 | 3.41 | 119 | 3 |
| | FEV1 | Liters | 2.36 | 2.24 | 95 | 1.85 | 78 | -17 |
| | FEV1/FVC | % | 84 | 68 | 81 | 54 | 65 | -20 |
| | FEF25-75% | L/sec | 2.60 | 1.71 | 66 | 1.01 | 39 | -41 |
| | FEF50% | L/sec | 3.29 | 2.46 | 75 | 0 98 | 30 | -60 |
| | FEF75% | L/sec | 1.14 | 0.64 | 56 | 0.63 | 55 | -1 |
| | PEF | L/sec | 5.60 | 3.23 | 58 | 2.83 | 51 | -12 |
| | FET100% | Sec | | 11.79 | | 10.77 | | -9 |
| | FIF50% | L/sec | | 1.15 | | 3.59 | | 212 |
| | PIF | L/sec | | 2.05 | | 3.78 | | 84 |
| | MVV | L/min | 95 | 101 | 106 | | | |
| Lung Volumes | | | | | | | | |
| | TLC | Liters | 4.56 | 8.14 | 178 | | | |
| | VC | Liters | 2.87 | 3.32 | 115 | | | |
| | IC | Liters | | 2.11 | | | | |
| | FRC PL | Liters | 2.49 | 6.03 | 243 | | | |
| | ERV | Liters | | 0.38 | | | | |
| | RV | Liters | 1.66 | 4.82 | 290 | | | |
| | RV/TLC | % | 37 | 59 | 162 | | | |
| Diffusing Capacity | | | | | | | | |
| | DLCO | mL/mmHg/min | 20.4 | 14.5 | 71 | | | |
| | DL Adj | mL/mmHg/min | 20.4 | 14.5 | 71 | | | |
| | DLCO/VA | mL/mHg/min/L | 4.01 | 3.97 | 99 | | | |
| | DL/VA Adj | mL/mHg/min/L | | 3.97 | | | | |
| | VA | Liters | | 3.66 | | | | |
| | IVC | Liters | | 2.40 | | | | |
| Resistance | | | | | | | | |
| | Raw | cmH2O/L/sec | 1.56 | 2.06 | 132 | | | |
| | Gaw | L/sec/cmH2O | 0.596 | 0.485 | 81 | | | |
| | Vtg (Raw) | Liters | | 6.44 | | | | |
| | Raw f | BPM | | 129 | | | | |




**Calibration Data:** Temp: 21 PBar: 765
Flow Cal Date: 05/27/16 Pred Volume: 3.00 Expire Avg: 2.98 Inspire Avg: 2.99
PF Reference: Knudson (1983) Version: IVS-0101-28-3b

Patient Name: Bean, Jeanne Faye
Date of Birth: 2/13/1960

MRN: 0000700630
FIN: 2001713696

* Auth (Verified) *

Memorial

***Memorial Hospital at Gulfport***
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**Date: 05/27/16**
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Age: 56 Height(in): 62.2
Weight(lb): 152 Gender: Female
Race: Caucasian
**Technician: Mary Everett, CRT**
**Physician: Carricka Thomas NP**

**Diagnosis: Shortness of Breath**

| | | | |
|---|---|---|---|
| Dyspnea Rest: No | Dyspnea Exercise: No | | |
| Cough: No | Persistent: No | Productive (cc): | |
| Smoker: Yes | Cigarettes: Yes | Cigars: No | Pipe: No |
| How Long: 30 | Quit: Yes | Stopped: 16 | |

Asthma? No

Emphysema? No

Pneumonia? Yes

Bronchitis? Yes

TB? No

Allergies? Yes codeine

Chest or Abdominal Surgery? Yes gall bladder

Heart disease? No

Chest pain? No

Cancer? No

***Comments:***

Good patient effort.
Hb assumed at 13.5.
Post treatment given with Albuterol.
FEF 25-75 / FVC % =52
Pt. had a hard time keeping a tight seal on the mouthpiece. Repeated lung volume test several times.

Bean, Jeanne Faye
DOB [redacted] 56 Y F
DOS: 05/27/2016 12:42
ATT: Thomas, Carricka NP
FIN: 2001713696
MRN: 0000700630

**Page 2**

**Memorial Hospital at Gulfport**

Patient Name: **Bean, Jeanne Faye** FIN: 2001713696
DOB: [redacted] MRN: 0000700630

## *Pulmonology Procedures*

| | |
|---|---|
| Document Type: | Pulmonary Function Studies |
| Service Date/Time: | 5/27/2016 12:42 CDT |
| Result Status: | Auth (Verified) |
| Perform Information: | Pakron,Fred MD (6/17/2016 17:17 CDT) |
| Sign Information: | Pakron,Fred MD (6/17/2016 17:17 CDT) |

**Performed by:Pakron, Fred MD on June 17, 2016 17:17 CDT**

Complete pulmonary function test 5/27/16 reveals mild airway obstruction based on the reduced FEF 25–75. The FEV1 value was actually quite good at 95%. Shape of the flow volume loop does suggest some very mild airway obstruction. There is no evidence of upper airway dysfunction. Lung volumes are increased consistent with overinflation of moderate degree. Diffusing capacity is reduced to a mild degree. The combination of obstruction and reduced diffusing capacity and overinflation is most consistent with emphysema of at least a mild degree. Clinical correlation is recommended

Electronically Signed on 06/17/2016 05:17 PM CDT

Pakron, Fred MD

# Report Regarding — James Bean

## Background

My name is Chelle Wilhelm, M.D. I received my M.D. from the University of Mississippi School of Medicine in 2007. I trained in internal medicine, pulmonary medicine, and allergy/immunology at the University of Mississippi Medical Center. I am licensed to practice medicine in Mississippi, board certified in Internal Medicine, Pulmonary Medicine, and Allergy/Immunology. I am a member of the American College of Allergy, Asthma, and Immunology, the American Academy of Allergy, Asthma, and Immunology, and the American College of Chest Physicians.

I am currently a practicing physician at Mississippi Asthma and Allergy Clinic, P.A. in Jackson, Mississippi. Attached to this report as Exhibit 1 is my curriculum vitae, which sets forth in greater detail my education, training, and publications.

I charge $500 per hour for records review, $1,000 per hour for medical clinic visits with plaintiffs and report drafting, and $1,500 per hour for testimony at trial.

## Allergic Rhinitis and Pulmonary Disease Related to Mold

As an allergist/immunologist, I routinely care for and treat patients with allergic rhinitis and various severity levels of asthma. I also care for and treat patients with other pulmonary disease related to mold, predominantly including Allergic Bronchopulmonary Aspergillosis (ABPA). I accordingly have extensive experience with the diagnosis and treatment of allergic rhinitis, asthma, and ABPA. Since I began practice, I have diagnosed and treated hundreds of patients with allergic rhinitis and asthma.

Allergic rhinitis is a common condition that is especially prevalent throughout the state of Mississippi. Allergic rhinitis is characterized by the allergic inflammation that involves a very complex set of immune cells, antibodies, and cytokines. However, at the center of an allergic response is the production of allergic immunoglobulin, known as IgE, to various allergens, including tree/grass/weed pollens, dog, cat, dust mites, cockroach, molds, etc. While there are other immune cells involved, the predominant cells include mast cells and eosinophils. Symptoms of allergic rhinitis include nasal congestion, runny nose, postnasal drainage, sneezing, and ocular pruritis and watering. These symptoms are triggered when a person who has been exposed to and has developed IgE antibodies to various allergens are exposed to these allergens in the environment. These allergens will bind to the IgE found on the surface of mast cells, and trigger them to release internal allergy mediators, including but not limited to histamine and leukotrienes. These mediators then mediate the allergic response and cause the person to have nasal congestion, sneezing, ocular pruritis, etc.

Asthma is also a common condition that can have various underlying cellular mechanisms. The most common form of asthma is known as allergic eosinophilic asthma and is characterized by elevated total IgE levels and specific IgE levels for various allergens, as well as elevated eosinophils. With this type of asthma, symptoms can be triggered much like the allergic rhinitis response with IgE antibodies and exposures to allergens that the person is sensitized to. If

exposed to a known allergen, this can trigger a person to have wheezing, cough, dyspnea, and chest tightness, the most common symptoms of asthma. Allergic bronchopulmonary aspergillosis is a complex pulmonary illness that is characterized by a noninfectious inflammatory response to mold organisms that are inhaled from the environment on an everyday basis. This illness is characterized by severe persistent asthma, often very difficult to control with standard therapy; elevated IgE and IgG antibody levels to aspergillus; and classic pulmonary findings, including central bronchiectasis, on high resolution CT scans of the chest.

Molds that are associated with disease in humans, including allergic rhinitis and asthma, as well as other mold mediated disease states, include, but are not limited to Aspergillus, Cladosporium, Bipolaris and Penicillium. Stachybotrys molds are not typically associated with allergic disease. These molds are sometimes erroneously referred to "toxic molds" because some species may produce mycotoxins. Stachybotrys and mycotoxins have been studied by the Centers for Disease Control and Prevention and no scientific studies have ever demonstrated a causal link between these molds that produce mycotoxins (known as toxigenic molds) and human disease. Molds are present at all times in our environment, some molds being predominantly outdoor molds while others are predominantly indoor molds. All people are exposed to molds on a daily basis, more so in different geographic locations, seasons and climates. Humidity levels influence allergen levels, particularly molds and house dust mites. High humidity environments, such as the Mississippi Gulf Coast, promote mold growth and increased house dust mite prevalence.

In my clinical practice, as I encounter patients with signs and symptoms of allergic rhinitis and asthma, there is a standard that is followed. The most important part of my visit with any patient is a clinical history to determine exactly what issues the patient may be having. Based on the history, this will lead me to any needed medical testing. Typically, this will include aeroallergen skin prick testing or aeroallergen in-vitro testing. Skin testing involves scratching the skin with the various aeroallergens to see if the patient will have an allergic response to the aeroallergen, i.e. a positive test. Testing by lab involves measuring the allergy antibody (IgE) level to the specific aeroallergens. If I am concerned about asthma or other pulmonary issue, this evaluation will include spirometry and/or chest imaging, typically a chest X-ray. These tests will then help guide treatment options and counseling on any environmental changes.

The standard treatment for allergic rhinitis includes antihistamine medications, antileukotriene medications, and intranasal corticosteroid and antihistamine sprays. The typical medications for asthma include inhaled corticosteroids, various long-acting and short-acting bronchodilators, and often times, bursts of oral corticosteroids and biologic therapies depending on the severity level. If a patient has allergic bronchopulmonary aspergillosis, often times, they require oral corticosteroids for 3-6 months in addition to some of the above therapies, followed by various bursts of oral steroids to maintain control.

With the abundance of information now available, especially with social media, it can be very difficult to separate fact from fiction regarding many topics, including mold. It is critically important to realize that exposure to mold does not necessarily mean people will be symptomatic, especially considering all homes have molds. Included is an excerpt from the Center for Disease Control and Prevention website.

"The term 'toxic mold' is not accurate. While certain molds are toxigenic, meaning they can produce toxins, (specifically mycotoxins), the molds themselves are not toxic or poisonous. Hazards presented by molds that may produce mycotoxins should be considered the same as other common molds which can grow in your house. There's always a little mold everywhere – in the air and on many surfaces. There are very few reports that toxigenic molds found inside homes can cause unique or rare health conditions such as pulmonary hemorrhage or memory loss. These case reports are rare, and a causal link between the presence of the toxigenic mold and these conditions has not been proven." www.cdc.gov/mold/stachy.htm.

**Medical History**

Mr. James Bean is a 67 year old (at the time of my medical interview on June 6, 2019) Caucasian man, who was seen as part of the Rule 35 examination regarding complaints of mold-related injuries from living in a home at 119 O'Donnell Drive. Review of the lease agreement reveals they were in this home from July 2, 2014 to August 31, 2016.[1] During our interview, he reported a past medical history significant for coronary artery disease (CAD), hypertension (HTN), hypercholesterolemia, and gastroesophageal reflux (GERD). He reported taking Nexium for GERD, as well as medications for CAD and HTN, although he could not recall the exact medications.

Review of medical records indicate that Mr. Bean was initially found to have an abnormal cardiac stress test on 6/13/07, when this demonstrated a mild reversible inferior defect suggesting ischemia.[2] Later, during a hospital admission in Tennessee in August 2007, he had a cardiac catherization, which revealed 99% stenosis in the distal right coronary artery, which was stented, and multiple areas of 30-50% stenosis in other areas of the right coronary artery, 60% stenosis in the circumflex artery, and 30% in the left anterior descending artery and 70% in a diagonal branch.[3] During a subsequent admission in Gulfport, MS, for unstable angina on 4/23/15, he had another stent placed to the mid-right coronary artery.[4] At the most recent cardiology visit seen in the medical records, on 12/11/18, he was doing well at his one-year follow-up. He again declined anticoagulation for paroxysmal atrial fibrillation, but his amlodipine dose was increased for better control of his HTN.[5] After review of his medical records, I am not certain when he was diagnosed with atrial fibrillation; however, the earliest mentioned appeared during an admission in Tennessee in August 2010.[6] Again, during an admission in January 2011, he was noted to be in atrial fibrillation and was started on sotalol.[7]

During our interview, he reported having issues with allergy symptoms, including nasal congestion, drainage, sneezing, snoring, hoarseness, sore throat, and ocular watering and redness.

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[1] Bean Initial Disclosures 622-623.

[2] Bean-James Bean-M003222.

[3] Bean-James Bean-M003219-00320.

[4] Bean-James Bean-M001203-001205.

[5] Bean-James Bean-M001384-001389.

[6] Bean-James Bean-M000300-000303.

[7] Bean-James Bean-M000218-000282.

Mr. Bean reported that he has had these issues for many years, but right now is doing ok and is not taking any routine medications for these complaints. He reported taking an antihistamine occasionally, as needed. He reported his allergy symptoms worsened while living in the home at Keesler and improved after he moved out. By review of his medical records, Mr. Bean was seen by an allergist many times for urticaria and angioedema while living in Tennessee. At a visit on 7/28/08, it was mentioned that he had "probable allergic rhinitis by history,"[8] and as far back as a visit on 7/12/07, he was on rhinocort, a nasal allergy spray.[9] During these visits to the allergist, attention was mainly focused on urticaria and angioedema, as the angioedema, in particular, was a large issue. However, at a visit on 9/10/08, a sinus Xray was ordered,[10] and this was interpreted by a radiologist as normal.[11] A CT sinus was done on 10/30/09 in Tennessee, and this was interpreted by a radiologist to have a small retention cyst or polyp in the right maxillary sinus, as well as a small focal area of mucosal thickening in the inferior medial right maxillary sinus which could represent a second retention cyst or sinusitis.[12] These visits with the allergist, and these imaging studies were done prior to moving to Mississippi.

While living in Mississippi, Mr. Bean was seen by his primary provider on 11/20/14 for congestion, sneezing, runny nose, and non-productive cough. He was treated at that time for possible bronchitis with azithromycin.[13] He was then seen on 12/4/14 with continued cough and drainage, and he was again treated for acute bronchitis with amoxicillin.[14] He was seen on 7/7/15 for chest congestion, cough, and malaise. He reported at that time to having been placed on doxycycline for bronchitis and sinusitis. He was again diagnosed with acute bronchitis, and five days of prednisone was added to his treatment plan.[15] An allergy lab panel was eventually checked on 1/15/14, and all were negative. Mr. Bean was negative for grass/tree/weed pollens, cat, dog, and dust mites. He was also negative to the following molds: penicillium chrysogenum, cladosporium herbarum, aspergillus fumigatus, and alternaria alternata/tenuis.[16]

Mr. Bean also reported recurrent hives and swelling, and he felt as though this may have worsened while living in the O'Donnell home. However, he stated that it was "hard to say." The swelling involved his lips, feet, hands, and groin. He reported that these issues would happen several times over several weeks, then skip and week or two before occurring again. He reported taking prednisone as needed for swelling. He recounted being seen by allergists, but no definitive answer for the swelling could be found. Review of his medical records indicates numerous visits for swelling. He was seen by an allergist for urticaria and angioedema numerous times while living in Tennessee between 2007 and 2012. He was initially seen on 7/12/07 for

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[8] Bean-James Bean-M002678-002679.

[9] Bean-James Bean-M002664-002665.

[10] Bean-James Bean-M002673.

[11] Bean-James Bean-M002852.

[12] Bean-James Bean-M000618-000619.

[13] Bean-James Bean-M002623.

[14] Bean-James Bean-M002622.

[15] Bean-James Bean-M003626-003627.

[16] Bean-James Bean-M002504-002506.

facial swelling, which was initially thought to possibly be related to an allergy to BC Powder.[17] However, swelling continued to be an issue, and lab work was checked to rule out a hereditary and acquired component. These labs were checked several times over the years. C3 and C4, C-reactive protein (CRP), antinuclear antibody (ANA), thyroid stimulating hormone (TSH), uric acid, rheumatoid factor (RF), erythrocyte sedimentation rate (ESR), and comprehensive metabolic panel (CMP) were normal on 2/18/09.[18] On 7/29/08, C1q complement component, C3/C4, C1 esterase inhibitor level and function, and a CH50 were checked and were either normal or elevated, but not low.[19] Again, on 9/17/10, C3 and C4 were normal, C1 esterase inhibitor level and CH50 were both normal, along with a negative IgE latex.[20] According to a note from his allergist on 8/31/10, he was diagnosed with chronic idiopathic urticaria and angioedema.[21] He was also seen by a dermatologist on 8/12/08 for angioedema and urticaria.[22] The allergist saw him during one of his hospital admissions in October 2009 for chronic idiopathic urticaria and angioedema.[23] He was also seen by his primary care provider and placed numerous phone call messages to his primary care provider. His visits included, but were not limited to, 8/9/08,[24] 8/12/08,[25] 8/31/10,[26] 9/16/10,[27] 10/27/10,[28] 10/19/11,[29] 1/25/12,[30] and 7/13/12.[31] All of these visits occurred prior to moving to Mississippi. While living in Mississippi, he was seen by a dermatologist in Ocean Springs, MS, on 1/7/14 for angioedema,[32] which was prior to moving into the O'Donnell home on July 2, 2014. He was then seen again on 9/9/14 for rash and angioedema,[33] and then by his primary care provider on 11/20/14 and reported that he had been very stressed for the past 6 months, and he was concerned about his 15 year history of hives that were getting worse.[34] He was seen by Dr. Niolet, an allergist in Ocean Springs, MS, on 1/15/14[35] and again on 1/30/14, who ultimately diagnosed him with idiopathic angioedema

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[17] Bean-James Bean-M002660-002665.

[18] Bean-James Bean-M001409-001413.

[19] Bean-James Bean-M002837-002841.

[20] Bean-James Bean-M000291.

[21] Bean-James Bean-M002676-002677.

[22] Bean-James Bean-M003000.

[23] Bean-James Bean-M002864-002865.

[24] Bean-James Bean-M002690-002691.

[25] Bean-James Bean-M002708.

[26] Bean-James Bean-M002715.

[27] Bean-James Bean-M002713.

[28] Bean-James Bean-M002700.

[29] Bean-James Bean-M002712.

[30] Bean-James Bean-M002714.

[31] Bean-James Bean-M002705.

[32] Bean-James Bean-M003098-003099.

[33] Bean-James Bean-M003095-003097.

[34] Bean-James Bean-M002623.

[35] Bean-James Bean-M001965-001968.

also, all prior to moving to the O'Donnell home.[36] He also checked an allergy panel on 1/15/14, and this was completely negative, as stated above.[37] After moving out of the home, he was again seen by his primary care provider on 9/22/16 to establish care and reported having hives.[38] He was seen again on 1/22/18 for angioedema and other health problems.[39] In January 2018, in Tennessee, he was admitted to the hospital for angioedema.[40]

Mr. Bean also reported issues with a chronic cough, shortness of breath, and sputum production during our interview. He stated that he continues to have some shortness of breath now, but that while he was in the home his symptoms were worse. He reported taking Symbicort daily while living in the home, but now takes it about once every 1-2 weeks. He reported a prior chest CT, but he did not recall performing a pulmonary function test (PFT). During review of medical records, several visits were seen related to pulmonary issues. As stated above, he was seen and diagnosed with bronchitis on 11/20/14,[41] 12/4/14,[42] and again on 7/7/15.[43] After leaving Mississippi, he was seen by a pulmonologist in Tennessee on 1/3/17 for dyspnea. During this visit, he reported that while working at Alcoa, he was exposed to many gases and coal tar pitch and asbestos. It was also noted that he had obstructive sleep apnea and was noncompliant with treatment. For further evaluation, a PFT, 6-minute walk test (6MWT), arterial blood gas (ABG), and chest Xray were ordered.[44] In his follow up visit on 1/25/17, the pulmonologist stated that his spirometry was normal, and that his lung volumes did not show restriction. He did have mild air trapping with a normal diffusion capacity. His 6MWT was essentially normal, as his oxygen did not drop below the threshold, and he was able to walk an acceptable distance. He was on ProAir at this visit, and this was refilled.[45] During the review of records, I did not see the results of the ABG. The chest Xray on 1/25/17 showed calcification of the thoracic aorta and that the lungs were over-expanded, but it was otherwise normal. The impression of the radiologist was arteriosclerosis and COPD with no active disease identified.[46]

Over the years of medical records reviewed, he has had numerous chest Xrays with the earliest noted on 1/7/02, which was interpreted to show a stable left upper lobe nodule.[47] He had a CT chest done on 1/28/02, which was interpreted to show a tiny nodule in the right upper lobe.[48] On

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[36] Bean-James Bean-M001969-001972.

[37] Bean-James Bean-M002504-002506.

[38] Bean-James Bean-M001996-001999.

[39] Bean-James Bean-M001983-001986.

[40] Bean-James Bean-M000132-000134.

[41] Bean-James Bean-M002623.

[42] Bean-James Bean-M002622.

[43] Bean-James Bean-M003626-003627.

[44] Bean-James Bean-M001396-001398.

[45] Bean-James Bean-M001399-001401.

[46] Bean Initial Disclsoures000019.

[47] Bean-James Bean-M001867.

[48] Bean-James Bean-M001861.

the chest Xray done on 9/17/10, the radiologist's impression was emphysematous hyperinflation with postinflammatory changes but no residual infiltrate.[49] On 2/15/12, the chest Xray showed that the lungs were over expanded, and the radiologist's impression was mild cardiomegaly, aortic atherosclerosis, COPD, but no active disease.[50] On 1/25/17, again the chest Xray showed that the lungs were over expanded, with the radiologist's impression being arteriosclerosis, and COPD, but no active disease.[51]

During our interview, Mr. Bean reported that he had been a heavy smoker, smoking about 2 packs per day (2 ppd) for about 20 years. He quit about 20 years ago. He also stated that he drank alcohol but quit in 2008. He also reported during our interview that he had joint pain and swelling and weakness and fatigue, but he did not correlate these with living in the home. His wife stated in the interview, however, that when living in the O'Donnell home, any health problem could have been worsened.

**Assessment**

In my opinion, Mr. Bean reported certain symptoms of rhinitis, including nasal congestion, sneezing, drainage. He also reported ocular watering and redness. However, even though he reported certain symptoms of rhinitis and allergic conjunctivitis, there is no indication that these symptoms were allergic in etiology, as he had negative allergy lab work in January 2014 for all aeroallergens, including molds. Furthermore, these symptoms were present well before he moved into the O'Donnell home, as he was seeing an allergist as far back as 2008 and was on rhinocort as far back as 2007. Mr. Bean also has a long history of urticaria and angioedema. He has been thoroughly evaluated by two different allergists, both eventually diagnosing idiopathic urticaria and angioedema. This is a very common illness seen by allergists, and essentially the etiology of the hives and swelling is not clear, as the symptoms are more spontaneous and not triggered by any specific sensitivity. These issues were present well before moving to Mississippi and continued after he left Mississippi. While in Tennessee, he had numerous visits with an allergist from 2007 to 2012. Environmental allergens do not typically trigger these swelling symptoms described by Mr. Bean and reported in the records, and regardless of this, his environmental allergen panel was negative.

Even though he may have had symptoms of rhinitis, one cannot say that these were, to a reasonable degree of medical certainty, related to mold exposure. This is supported by the fact that there would typically be other indoor allergens to consider that could have caused his symptoms, predominantly indoor exposure to dust mites, which is also very prevalent in areas of high humidity. They had carpet in the O'Donnell home throughout the upstairs, which increases exposure to dust mites. They also had a dog inside the home, and in addition, outdoor allergens, such as grass pollen, are brought into the home on a routine basis, essentially causing indoor exposure as well. Furthermore, people are exposed to molds on a routine basis, as molds are ubiquitous in nature. In my opinion, no one can say with any medical certainty that his symptoms were related to mold exposure in the Keesler home.

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[49] Bean-James Bean-M000296.

[50] Bean-James Bean-M001364.

[51] Bean-James Bean-M001365.

Additionally, he reported symptoms of shortness of breath and cough. The PFT and CXR findings can be consistent with COPD related to his smoking history, and these findings were present on imaging well before moving into the O'Donnell home. Furthermore, there is no indication that these symptoms are allergic in etiology, as, again, his allergy testing was negative. Also, certain cardiac issues can also contribute to shortness of breath and cough. Again, no one can say to a reasonable degree of medical certainty that Mr. Bean's symptoms were related to mold exposure in the Keesler home. Regarding his other issues, including weakness and fatigue, as well as joint pain and swelling, there is no link between mold allergen sensitivities and these medical symptoms. In my opinion, these conditions were not caused or worsened in any way due to mold sensitivity.

While Mr. Bean lived at the 119 O'Donnell home between July 2, 2014 and August 31, 2016, no mold testing was done on the home to determine what, if any, mold was actually inside the home. Even if the symptoms reported by Mr. Bean could be allergic in nature, the symptoms cannot be attributed to exposure to mold in the home because those same molds are common everywhere, and the Beans had no testing in the home to determine what, if any, mold was actually inside the home. As stated previously, Mr. Bean negatively tested for the most common molds. Therefore, to a reasonable degree of medical certainty the reported symptoms were not caused by mold in the O'Donnell home.

In conclusion, to a reasonable degree of medical certainty, James Bean's medical issues were not caused or worsened by exposure to mold in his Keesler home. In addition, I do not believe any of Mr. Beans's prior or ongoing medical treatments are attributable to mold exposure in his Keesler Air Force Base home.

All of the opinions that I express in this report are held to a reasonable degree of medical certainty. The opinions are based on medical records and materials I reviewed regarding Mr. Bean, as well as a clinical interview and exam that I conducted with Mr. Bean personally. The opinions are also based on my education, training, and experience.

Attached to this report is a medical summary of our clinic visit, as well as the findings on my physical exam. This is Exhibit 2. Also attached to this report are the following chest Xrays: 1/7/02, Exhibit 3;[52] 9/17/10, Exhibit 4;[53] 2/15/12, Exhibit 5;[54] and 1/25/17, Exhibit 6.[55] Also attached as Exhibit 7 is the CT chest done on 1/28/02.[56] Attached as Exhibit 8 is his allergen lab

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[52] Bean-James Bean-M001867.

[53] Bean-James Bean-M000296.

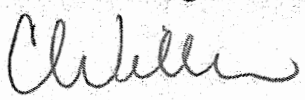
[54] Bean-James Bean-M001364.

[55] Bean-James Bean-M001365.

[56] Bean-James Bean-M001861.

panel done on 1/15/14.[57] Exhibit 9 is the sinus Xray done on 9/10/08,[58] and Exhibit 10 is the CT sinus done on 10/30/09.[59]

I reserve the right to amend this report upon receipt of additional information.



Chelle P. Wilhelm, M.D.

[57] Bean-James Bean-M002504-002506.

[58] Bean-James Bean-M002852.

[59] Bean-James Bean-M000618-000619.

# Curriculum Vitae


## Chelle P. Wilhelm, M.D.

154 Rolling Meadows Road
Ridgeland, MS 39157
601-917-0940
chellepwilhelm@gmail.com


**Employment:**

Mississippi Asthma and Allergy Clinic, P.A. 2017-current
1513 Lakeland Drive, Suite 101
Jackson, MS 39216
601-354-4836

University of Mississippi Medical Center 2015-2017
Assistant Professor of Medicine and Pediatrics
Department of Medicine
Division of Clinical Immunology and Allergy
601-815-1078

**Language Proficiency:** English

**Education:**

| | |
|---|---|
| 2003-2007 | Doctor of Medicine<br>University of Mississippi Medical Center School of Medicine<br>Jackson, MS |
| 1999-2003 | B.S. Microbiology, *Summa Cum Laude*<br>Mississippi State University<br>Starkville, MS |

**Post-Doctoral Training:**

| | |
|---|---|
| 2013-2015 | Clinical Immunology and Allergy Fellowship<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2011-2013 | Pulmonary Medicine Fellowship<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2010-2011 | Chief Internal Medicine Resident<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2007-2010 | Internal Medicine Internship and Residency<br>University of Mississippi Medical Center<br>Jackson, MS |

**Licensure:**

| | |
|---|---|
| 2016 | American Board of Allergy and Immunology<br>Recertify: 2026 |
| 2013 | American Board of Pulmonary Medicine<br>Recertify: 2023 |
| 2010 | American Board of Internal Medicine<br>Recertify: 2020 |
| 2009 | Mississippi State Medical Licensure- Expires 6/30/19 |

**Recognitions/Honors/Awards:**

| | |
|---|---|
| 2007 | James E. Griffith Pulmonary Award |
| 2000-2001 | Mississippi State University Honors Award |
| 1999-2003 | Mississippi State University President's Scholar |

**Other Professional Appointments and Activities:**

| | |
|---|---|
| 2013-2014 | American College of Physicians Fellowship Council<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2013-2014 | Introduction to Clinical Medicine Preceptor- second year medical students<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2009-2011 | Introduction to Clinical Medicine Preceptor- second year medical students<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2009 | Co-Leader of Introduction to Clinical Medicine "Fridays at the Bedside" for introduction of second year medical students to patient care<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2009 | Residency Improvement Council<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2007-2011 | American College of Physicians Resident Council<br>University of Mississippi Center<br>Jackson, MS |

**Professional Committees:**

| | |
|---|---|
| 2016-2017 | Ethics Advisory Committee<br>Chaired by: Kathy Gregg, MD<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2015-2016 | Program Evaluation Committee- Allergy/Immunology Program<br>University of Mississippi Medical Center<br>Jackson, MS |
| 2011-2015 | Resident Review Committee<br>University of Mississippi Medical Center |

Jackson, MS

**Society Memberships:**

| | |
|---|---|
| 2015-current | Mississippi Society of Asthma, Allergy, and Immunology |
| 2015-current | Mississippi State Medical Association (MSMA) |
| 2013-current | American College of Allergy, Asthma, and Immunology (ACAAI) |
| 2013-current | American Academy of Allergy, Asthma, and Immunology (AAAAI) |
| 2010-current | American College of Chest Physicians (ACCP) |
| 2010-2016 | American Thoracic Society (ATS) |

**Clinical Research:**

| | |
|---|---|
| 2013-2017 | A Randomized, Double-blind, Placebo-controlled Study to Evaluate the Safety and Efficacy of Brodalumab in Subjects with Inadequately Controlled Asthma and High Bronchodilator Reversibility. Amgen. Sub-investigator; Primary investigator- Dr. Gailen Marshall. |
| 2013-2017 | A 26 Week, Randomized, Double-blind, Parallel-group, Active Controlled, Multicenter, Multinational Safety Study Evaluating the Risk of Serious Asthma-related Events During Treatment with Symbicort, a Fixed Combination of Inhaled Corticosteroids (ICS) (Budesonide) and a Long Acting Beta-agonist (LABA) (Formoterol) as Compared to Treatment with ICS (Budesonide) Alone in Adult and Adolescent (>12 years of Age) Patients with Asthma. AstraZeneca. Sub-investigator; Primary investigator- Dr. Gailen Marshall |

**External Peer Reviewer of Evidence-Based Medicine:**

2015-current Reviewer for *Annals of Allergy, Asthma, and Immunology*

**Publications:**

Peer-Reviewed

Wilhelm CP, Chipps BE. Bronchial Thermoplasty: A Review of the Evidence. Ann Allergy Asthma Immunol. 2016;116:92-98.

Wilhelm CP, deShazo RD, Tamanna S, Ullah MI, Skipworth LB. The Nose, Upper Airway, and Obstructive Sleep Apnea. Ann Allergy Asthma Immunol. 2015;115(2):96-102.

Pope CR, Wilhelm AM, Marshall GD. Psychological Stress Interventions and Asthma: Therapeutic Considerations. JCOM. 2014;21:570-76.

Tamanna S, Ullah MI, Pope CR, Holloman G, Koch CA. Quetiapine-induced Sleep-related Eating Disorder-like Behavior. A Case Series. J Med Case Rep. 2012;6:380.

Book Chapter

Pope CR, deShazo RD. "Age- Co-Morbid and Co-Existing." *Asthma, Comorbidities, Co-Existing Conditions, and Differential Diagnosis.* Oxford University Press; 2014.

**Abstracts/Presentations:**

Pulmonary Infiltrates with Eosinophilia in a 7-Week Old Infant. Pope CR, Hall AG, Dave N, Yates AB. Poster presentation at American College of Allergy, Asthma, and Immunology Annual Meeting. Baltimore, MD 2013

A Case of Excessive Kerley Lines. Oral Presentation of patient with Erdheim Chester Disease. Tri-State Pulmonary Conference. New Orleans, LA 2012.

**University Teaching Conferences:**

Allergic Bronchopulmonary Aspergillosis for Pulmonary Fellows- April 12, 2017

Interstitial Lung Disease for Allergy/Immunology Fellows- March 17, 2017

Asthma Guidelines for Internal Medicine Residents- August 18, 2016

Rhinoscopy Instruction and Demonstration for Allergy/Immunology Faculty, Fellows, and Nursing staff- June 10, 2016

Wegener Granulomatosis for Allergy/Immunology Fellows- May 20, 2016

Pulmonary Function Testing Interpretation for Allergy/Immunology Fellows- January 29, 2016; August 25, 2016

Chronic Obstructive Pulmonary Disease (COPD) for Allergy/Immunology Fellows- November 13, 2015

Asthma Guidelines for Family Medicine Residents- December 3, 2015

**Regional Teaching Conferences:**

Assessment, Diagnosis, and Monitoring for Asthma- American Lung Association Asthma Educators Institute- Jackson, MS, April 19, 2017

Asthma Update for Primary Care Physician- Hazelhurst, MS, October 17, 2016

**Community Activities:**

American Lung Association, Board Member 2017- current

# History and Physical

| | | | |
|---|---|---|---|
| **Patient Name:** | James Bean | **Create Date:** | June 30, 2019 |
| **Patient ID:** | 327546 | | |
| **Sex:** | Male | | |
| **Birthdate:** | [redacted] | | |

## Chief Complaint

Rule 35 Examination

## History Of Present Illness

Patient seen for Rule 35 Examination.

Mr. Bean reported that he has coronary artery disease and has had stents placed x 2, once in TN and once in MS. He reported that he has HTN and takes medications for this, but not sure what they are. He stated that he has GERD and takes nexium for this, and has hypercholesterolemia but was not sure what the name of the medicine is that he takes for this.

He reported that he has a history of swelling, particularly lip swelling, and has been hospitalized for this. He also reported having recurrent hives. He stated that these will occur several times over a week or so, and then he will not have isues for a week or two. The swelling has involved his lips, feet, hands, and groin. He takes steroids PRN for this. He reported that the frequency of the swelling and hives may have increased while he was living in the home, but he was not certain of this.

He also reported vision loss, nasal congestion, post nasal drainage, sneezing, snoring, sore throat, hoarseness, hearing loss, and watering/redness of the eyes. He stated he had had issued for years with these symptoms, but the symptoms were more severe when he was living in the home. He reported that he is not taking any routine medicines for this now, but only antihistamines PRN. He also stated that while he was in the home he had fairly frequent headaches. Since moving out of the home, he has had maybe 1 HA every 1-2 months and these are milder in severity.

Also, he stated that he has a chronic cough, SOB, and sputum production. He reported that he still have issues with SOB predominantly. He took symbicort daily while in the home, but now, takes it PRN. He will typically need it about 1 time every 1-2 weeks. He has had a CT done, but he does not recall having a PFT.

He also reported heartburn, weakness/fatigue, joint swelling and pain, but these were not necessarily correlated to living in the home.

He drank alcohol until 2008 but hasn't since that time. He smoked about 2 ppd x 20 years, and he quit 20 years ago. He does have a poodle in the home, and this dog was with them while they lived in the home related to this Rule 35 examination. This home had carpeting upstairs, but the home he lives in now, only has carpeting in the bedroom.

## Past Medical History

| Disease Name | Date Onset | Notes |
|---|---|---|
| CAD (coronary artery disease) | -- | -- |
| GERD | -- | -- |
| Hypercholesteremia | -- | -- |
| Hypertension | -- | -- |

## Past Surgical History

| Procedure Name | Date | Notes |
|---|---|---|
| Colon surgery | -- | -- |
| Eye Surgery | -- | -- |

| | | |
|---|---|---|
| STENT Placement | -- | -- |
| Tonsillectomy | -- | -- |

## Medication List

Reviewed None Changed

## Allergy List

| Allergen Name | Date | Reaction | Notes |
|---|---|---|---|
| SULFA(SULFONAMIDE ANTIBIOTICS) | -- | -- | -- |

## Family Medical History

Reviewed None Changed

## Social History

| Finding | Status | Start/Stop | Quantity | Notes |
|---|---|---|---|---|
| Alcohol | -- | --/-- | -- | Quit in 2008 |
| Carpet | -- | --/-- | -- | -- |
| Former smoker | -- | --/-- | -- | Smoked about 2 ppd x 20 years, quit 20 years ago. |
| Indoor Pets | -- | --/-- | -- | -- |

## Review of Systems

**Constitutional**
- **Denies** : fever, night sweats

**Eyes**
- **Admits** : See HPI

**HENT**
- **Admits** : See HPI

**Breasts**
- **Denies** : tenderness

**Cardiovascular**
- **Admits** : See HPI

**Respiratory**
- **Admits** : See HPI

**Gastrointestinal**
- **Admits** : See HPI

**Genitourinary**
- **Denies** : urinary retention, dysuria, frequency

**Integument**
- **Admits** : See HPI

**Neurologic**
- **Admits** : See HPI

**Musculoskeletal**
- **Admits** : See HPI

**Endocrine**
- **Denies** : inappropriate weight gain, inappropriate weight loss

**Psychiatric**
- **Denies** : anxiety, depression

**Heme-Lymph**
- **Denies** : lymph node enlargement or tenderness, recurrent fevers, easy bleeding, easy bruising

**Allergic-Immunologic**
- **Denies** : recurrent infections, unusual infections

**All Others Negative**

## Vitals

| Date | Time | BP | Position | Site | L\|R | Cuff Size | HR | RR | TEMP (F) | WT | HT | BMI kg/m² | BSA m² | O2 Sat |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 06/30/2019 | 03:16 PM | 162/86 | Sitting | | | | 55 - R | | 98.5 | 150lbs 0oz | 5' 6" | 24.21 | 1.78 | 98 % |

## Physical Examination

**Constitutional**
- **Appearance** : well nourished, alert, in no acute distress

**Eyes**
- **Conj, Sclera, Lids** : conjunctiva normal, sclera white without injection, eyelid appearance normal
- **Pupils and Irises** : pupils equal, round, reactive to light

**HENT**
- **Head** : normocephalic
- **Ears - External** : external ears within normal limits
- **Ears - Otoscopic** : tympanic membranes intact without erythema, external auditory canals clear
- **Ears - Hearing** : hearing intact bilaterally
- **Nose** : external nose normal appearance, nares patent, nasal mucosa pink, septum midline, turbinates benign and no masses; no drainage
- **Mouth and Lips** : oral mucosa pink and moist, lip appearance normal
- **Oropharynx** : oropharynx clear without erythema or exudates, tonsils benign

**Neck**
- **Neck** : normal size, normal appearance

**Chest**
- **Respiratory Effort** : breathing unlabored, no retractions or accessory muscle use
- **Auscultation** : breath sounds clear bilaterally

**Cardiovascular**
- **Auscultation** : regular rate, normal rhythm, no murmurs present
- **Peripheral circulation** : without edema, cyanosis

**Psychiatric**
- **Judgement, insight** : judgement and insight intact
- **Orientation** : oriented to person,place and time
- **Mood and affect** : normal affect

**Musculoskeletal**
- **Digits and Nails** : no clubbing, cyanosis, normal appearing nails, no deformities present

**Skin**
- **Inspection** : no rashes present, no lesions present
- **Palpation** : no palpable rashes

**Electronically Signed by:** Chelle Wilhelm, MD -Author on June 30, 2019 03:47:32 PM

The University of Tennessee Memorial Hospital
1924 Alcoa Hwy. Knoxville, TN 37920
(423) 544-9060
Radiology Consultation Report

BEAN, JAMES R
MR.: 0405873
Location: OPXR
Sex: Male
Age: 49 Years
Attending Dr.: Emmett, Kim R
Account #: 2960169

Consulting Dr.:
Accession #: DX-02-0001822

Radiology Report:
DX Chest, 2 Views, PA & Lat. 01/07/02
Ordering:
Emmett, Kim R

Reason for exam:
chest pain

Results
REASON: Chest pain.

Two views, COMPARISON: 08/06/00. Multiple calcified small granulomas are scattered throughout lungs. There is a small nodular density over the left upper lung on frontal view which is unchanged over 08/06/00. No other significant abnormality. Old healed right clavicle fracture.

OPINION:

STABLE LEFT UPPER LUNG NODULE SINCE 08/06/00. ORDINARILY STABILITY SHOULD BE DOCUMENTED OVER TWO YEAR PERIOD FOR CLEARANCE, THUS I WOULD SUGGEST A FINAL FOLLOWUP CHEST X-RAY IN ABOUT 8 MONTHS. NO ACUTE PROCESS IS SEEN IN THE CHEST, HOWEVER.

Radiologist ALLEN JR, ANTON M

Authenticating Date 01/07/2002 17:18
Transcripton: KJM 01/07/2002 16:39



PRINTED BY: CHACKLER
DATE 2/18/2019

09:01:33 09/17/10 O R I G I N A L

BLOUNT MEMORIAL HOSPITAL
Maryville, TN
RADIOLOGY REPORT
RADIOLOGY REPORT

MR#: 000421788
ACCOUNT#: 3863039
NAME: BEAN, JAMES ROBERT
DOB: [redacted]
ADM DATE: 09/17/2010

ORDERING PROVIDER: EMMETT,KIMBERLY
ORDER #: 0607911
ACCESSION #: 580833
EXAM: XR CHEST 2 VIEW
EXAM DATE: 09/17/2010
CLINICAL: F/U PNEUMONIA

HISTORY: Followup pneumonia

COMPARISON: 8/27/2010

FINDINGS: The lungs are hyperinflated. There is flattening of both hemidiaphragms. Minimal residual postinflammatory changes are seen with no infiltrates. Cardiac size is normal.

IMPRESSION: Emphysematous hyperinflation with postinflammatory changes. No residual infiltrates.
Dictated on: 09/17/2010 08:56:21
Interpreted by: Cox, James K
Transcribed by: <None>
Signed by: Cox, James K

ApprovedDate: 09/17/2010 09:01 AM

RADIOLOGY REPORT

B3026 W

Blount Memorial Hospital
907 East Lamar Alexander Parkway
Maryville TN,37804

Radiology Department
(865) 977-5566
Fax: (865) 977-5662

## Diagnostic Report
## Status: Final

**Name:** BEAN, JAMES, ROBERT
**MRN:** 000421788
**Accession:** 789341
**DOB:** [redacted]
**Exam Completed:** 02/15/2012 11:45 AM EST
**Sex:** M
**EXAM(S):** XR CHEST 2 VIEW
**Account #:** 4150029

**ORDERING PHYSICIAN :** WEATHERBEE, TAYLOR C, Cardiologist

**ATTENDING PHYSICIAN:** WEATHERBEE, TAYLOR C, Cardiologist

BLOUNT MEMORIAL HOSPITAL
Maryville, TN
RADIOLOGY REPORT
MR#: 000421788
ACCOUNT#: 4150029
NAME: BEAN, JAMES ROBERT
DOB: [redacted]
ADM DATE: 02/15/2012

#_____ MD _____/ DATE_____
ROUTE AS FOLLOWS:
1. To MD_____ Date_____
2. To PE_____ Date_____
3. To Nurse_____ Date_____
4. To Trans_____ Date_____
5. To File_____ Date_____
6. To Scan & File 2/16 Date_____
PULL CHART _____

ORDERING PROVIDER: WEATHERBEE,TAYLOR
ORDER #: 2611423
ACCESSION #: 789341
EXAM: XR CHEST 2 VIEW
EXAM DATE: 02/15/2012
CLINICAL: SOB
IMPRESSION: MILD CARDIOMEGALY. COPD, AORTIC ATHEROSCLEROSIS. NO ACTIVE LUNG DISEASE.
DISCUSSION: The heart is mildly enlarged. The thoracic aorta is calcified. The lungs are over-expanded. No active infiltrate, uncalcified nodule, congestive failure, or pleural effusion is found.

COMPARISON: 2/1/2011
Dictated on: 02/15/2012 11:55:27
Interpreted by: Cotten, Daniel W
Transcribed by: <None>
Signed by: Cotten, Daniel W

Electronically Signed By: Roberts, Bruce T MD 01/30/2017 01:25:09 PM

Blount Memorial Hospital
266 Joule Street
Alcoa TN,

Radiology Department
(865) 984-3864

## Diagnostic Report
## Status: Final

**Name:** BEAN, JAMES, ROBERT
**MRN:** 000421788
**Accession:** 1702535
**DOB:** [redacted]
**Exam Completed:** 01/25/2017 8:00 AM EST
**Sex:** M
**EXAM(S):** XR CHEST 2 VIEW
**Account #:** 9111070

**ORDERING PHYSICIAN :** ROBERTS, BRUCE T, MD

**ATTENDING PHYSICIAN:** ROBERTS, BRUCE T, MD

REASON FOR EXAM: R06.09 Other forms of dyspnea

IMPRESSION: ARTERIOSCLEROSIS AND COPD. NO ACTIVE DISEASE IDENTIFIED.

DISCUSSION: There is calcification of the thoracic aorta. The lungs are over-expanded. No active infiltrate, uncalcified nodule, congestive failure, or pleural effusion is identified. The heart is not enlarged.

COMPARISON: 2/15/2012

Dictated on: 1/25/2017 4:30 PM
Interpreted by: Daniel W Cotten, M.D.
Transcribed by: Powerscribe 360
Signed by: Daniel W Cotten, M.D.

The University of Tennessee Memorial Hospital
1924 Alcoa Hwy. Knoxville, TN 37920
(423) 544-9060
Radiology Consultation Report

BEAN, JAMES R
MR.: 0405873
Location: OPCT
Sex: Male
Age: 49 Years
Attending Dr.: Emmett, Kim R
Account #: 3043908

Consulting Dr.:
Accession #: CT-02-0003026

Radiology Report:
CT Thorax, With IV Contrast 01/28/02
Ordering:
Emmett, Kim R

Reason for exam:
chest pain

Results
REASON: Chest pain.

RADIOPHARMACEUTICAL: Sections were obtained through the chest following infusion of Omnipaque-300.

There is a tiny nodule in the right upper lobe (image 15). Calcified granulomata are also seen bilaterally. No mediastinal or hilar adenopathy is detected. No pleural effusion is identified.

IMPRESSION:

TINY NODULE IN THE RIGHT UPPER LOBE. FURTHER EXAMINATION IN THREE MONTHS IS SUGGESTED. NO MEDIASTINAL OR HILAR ADENOPATHY IS DETECTED.

Radiologist King, Bernadette M.

Authenticating Date 01/29/2002 12:06
Transcripton: KAS 01/28/2002 14:50



PRINTED BY: CHACKLER
DATE 2/18/2019

**All Orders - Lab (continued)**

| Component | Value | Reference Range | Flag | Lab |
|---|---|---|---|---|
| CRP | <0.29 | 0.00 - 0.30 mg/dL | — | OSH LAB |

Testing Performed By

| Lab - Abbreviation | Name | Director | Address | Valid Date Range |
|---|---|---|---|---|
| **29 - OSH LAB** | OCEAN SPRINGS HOSPITAL LAB | Unknown | 3109 BIENVILLE BLVD OCEAN SPRINGS MS 39564 | 12/14/11 2118 - 11/24/15 2026 |

**Allergen Respiratory Panel 6 South Centr [20169151]**

Electronically signed by: **Pamela D Richmond on 01/15/14 0920** Status: **Completed**
Ordering user: Pamela D Richmond 01/15/14 0920
Frequency: 01/15/14 -

Resulted: 01/17/14 2028, Result status: Final result

Allergen Respiratory Panel 6 South Centr [20169164]
Resulting lab: QUEST DIAGNOSTICS NICHOLS INSTITUTE

Specimen Information

| ID | Type | Source | Collected On |
|---|---|---|---|
| 14Y-015F0007 | Blood | — | 01/15/14 0920 |

Components

| Component | Value | Reference Range | Flag | Lab |
|---|---|---|---|---|
| Cat Epithelium/Dander IgE | < 0.35 | <0.35 kU/L | — | SR SP |
| Dog Dander IgE | < 0.35 | <0.35 kU/L | — | SR SP |
| Bermuda Grass IgE | < 0.35 | <0.35 kU/L | — | SR SP |
| Meadow Grass, Kentucky Blue IgE | < 0.35 | <0.35 kU/L | — | SR SP |
| Johnson Grass IgE | < 0.35 | <0.35 kU/L | — | SR SP |
| Cockroach, German IgE | < 0.35 | <0.35 kU/L | — | SR SP |
| Dermatophagoides pteronyssinus IgE | < 0.35 | <0.35 kU/L | — | SR SP |
| Dermatophagoides farinae IgE | < 0.35 | <0.35 kU/L | — | SR SP |
| Penicillium chrysogenum IgE | < 0.35 | <0.35 kU/L | — | SR SP |
| Cladosporium herbarum IgE | < 0.35 | <0.35 kU/L | — | SR SP |
| Aspergillus fumigatus IgE | < 0.35 | <0.35 kU/L | — | SR SP |
| Alternaria alternata/tenuis IgE | < 0.35 | <0.35 kU/L | — | SR SP |
| Oak IgE | < 0.35 | <0.35 kU/L | — | SR SP |
| Elm IgE | < 0.35 | <0.35 kU/L | — | SR SP |
| Walnut Tree Pollen IgE | < 0.35 | <0.35 kU/L | — | SR SP |
| Pecan (Hickory) IgE | < 0.35 | <0.35 kU/L | — | SR SP |
| Short (Common) Ragweed IgE | < 0.35 | <0.35 kU/L | — | SR SP |
| Rough Marshelder IgE | < 0.35 | <0.35 kU/L | — | SR SP |

Comment:

**All Orders - Lab (continued)**

REFERENCE RANGES for Allergen IgE tests:

| IgE (kU/L) | Interpretation |
|---|---|
| < 0.35 | Class 0 - Below Detection |
| 0.35 - 0.69 | Class 1 - Low |
| 0.70 - 3.49 | Class 2 - Moderate |
| 3.50 - 17.49 | Class 3 - High |
| 17.50 - 49 | Class 4 - Very High |
| 50 - 99 | Class 5 - Very High |
| >=100 | Class 6 - Very High |

@ Test Performed By:
Quest Diagnostics Nichols Institute
Michael C. Dugan, M.D., FCAP., Laboratory Director
27027 Tourney Road
Valencia, CA 91355-5386
CLIA #05D0550302

Testing Performed By

| Lab - Abbreviation | Name | Director | Address | Valid Date Range |
|---|---|---|---|---|
| **1230700074 - SR SP** | QUEST DIAGNOSTICS NICHOLS INSTITUTE | DR. POWERS PETERSON | 27027 TOURNEY ROAD VALENCIA CA 91355-5386 | 03/16/12 1921 - Present |

**Allergen Bahia Grass IgE [20169152]**

Electronically signed by: **Pamela D Richmond on 01/15/14 0920** Status: **Completed**
Ordering user: Pamela D Richmond 01/15/14 0920
Frequency: 01/15/14 -

Resulted: 01/17/14 1832, Result status: Final result

Allergen Bahia Grass IgE [20169165]
Resulting lab: QUEST DIAGNOSTICS NICHOLS INSTITUTE

Specimen Information

| ID | Type | Source | Collected On |
|---|---|---|---|
| 14Y-015F0006 | Blood | — | 01/15/14 0920 |

Components

| Component | Value | Reference Range | Flag | Lab |
|---|---|---|---|---|
| Bahia Grass IgE | < 0.35 | <0.35 kU/L | — | SR SP |

Comment:

REFERENCE RANGES for Allergen IgE tests:

| IgE (kU/L) | Interpretation |
|---|---|
| < 0.35 | Class 0 - Below Detection |
| 0.35 - 0.69 | Class 1 - Low |
| 0.70 - 3.49 | Class 2 - Moderate |
| 3.50 - 17.49 | Class 3 - High |

**All Orders - Lab (continued)**

| | |
|---|---|
| 17.50 - 49 | Class 4 - Very High |
| 50 - 99 | Class 5 - Very High |
| >=100 | Class 6 - Very High |

@ Test Performed By:
Quest Diagnostics Nichols Institute
Michael C. Dugan, M.D., FCAP., Laboratory Director
27027 Tourney Road
Valencia, CA 91355-5386
CLIA #05D0550302

Testing Performed By

| Lab - Abbreviation | Name | Director | Address | Valid Date Range |
|---|---|---|---|---|
| **1230700074 - SR SP** | QUEST DIAGNOSTICS NICHOLS INSTITUTE | DR. POWERS PETERSON | 27027 TOURNEY ROAD VALENCIA CA 91355-5386 | 03/16/12 1921 - Present |

**Allergen Timothy Grass IgE [20169153]**

Electronically signed by: **Pamela D Richmond on 01/15/14 0920** Status: **Completed**
Ordering user: Pamela D Richmond 01/15/14 0920
Frequency: 01/15/14 -

Resulted: 01/17/14 1832, Result status: Final result

Allergen Timothy Grass IgE [20169166]
Resulting lab: QUEST DIAGNOSTICS NICHOLS INSTITUTE

Specimen Information

| ID | Type | Source | Collected On |
|---|---|---|---|
| 14Y-015F0006 | Blood | — | 01/15/14 0920 |

Components

| Component | Value | Reference Range | Flag | Lab |
|---|---|---|---|---|
| Timothy Grass IgE | < 0.35 | <0.35 kU/L | — | SR SP |

Comment:

REFERENCE RANGES for Allergen IgE tests:

| IgE (kU/L) | Interpretation |
|---|---|
| < 0.35 | Class 0 - Below Detection |
| 0.35 - 0.69 | Class 1 - Low |
| 0.70 - 3.49 | Class 2 - Moderate |
| 3.50 - 17.49 | Class 3 - High |
| 17.50 - 49 | Class 4 - Very High |
| 50 - 99 | Class 5 - Very High |
| >=100 | Class 6 - Very High |

@ Test Performed By:
Quest Diagnostics Nichols Institute
Michael C. Dugan, M.D., FCAP., Laboratory Director
27027 Tourney Road

Blount Memorial Hospital
907 East Lamar Alexander Parkway
Maryville TN,37804

Radiology Department
(865) 977-5566
Fax: (865) 977-5662

57/87 TCP
9-10-08 TCP/MV

HM- 983-6407
Cell- 789-9807

**Diagnostic Report**
**Status: Final**

**Name:** BEAN, JAMES, ROBERT
**MRN:** 000421788
**Accession:** 250234
**DOB:** [redacted]
**Exam Completed:** 09/12/2008 9:51 AM EDT
**Sex:** M
**EXAM(S):** XR SINUSES
**Account #:** 3448038

**ORDERING PHYSICIAN :** PRINCE, TIDENCE L

**ATTENDING PHYSICIAN:** PRINCE, TIDENCE L

BLOUNT MEMORIAL HOSPITAL
Maryville, TN
RADIOLOGY REPORT
MR#: 000421788
ACCOUNT#: 3448038
NAME: BEAN, JAMES ROBERT
DOB:·05/05/1952
ADM DATE: 09/12/2008

ORDERING PROVIDER: PRINCE,TIDENCE
ORDER #: 2769997
ACCESSION #: 250234
EXAM: XR SINUSES
EXAM DATE: 09/12/2008
CLINICAL: CHRONIC SINUSITIS
IMPRESSION: No acute fracture, malalignment, or bony destructive lesion. No significant mucosal thickening is identified in the paranasal sinuses. If further evaluation is needed, a CT of sinuses should be performed.
Dictated on: 09/12/2008 10:34:19
Interpreted by: Cotten, Daniel W
Transcribed by: <None>
Signed by: Cotten, Daniel W

09:40:53 10/30/09 O R I G I N A L

BLOUNT MEMORIAL HOSPITAL
Maryville, TN
CT SCAN REPORT
RADIOLOGY REPORT

MR#: 000421788
ACCOUNT#: 3684610
NAME: BEAN, JAMES ROBERT
DOB: [redacted]
ADM DATE: 10/30/2009

ORDERING PROVIDER: PRINCE,TIDENCE
ORDER #: 4339469
ACCESSION #: 451114
EXAM: CT SINUS LIMITED STUDY
EXAM DATE: 10/30/2009
CLINICAL: CHRONIC SINUITIS

HISTORY: Chronic sinusitis

COMPARISON: None

FINDINGS:

Coronal sinus CT is performed using thin section helical axial images. Coronal reformatted images are obtained.

In the inferior aspect of the right maxillary sinus there is a 7 x 12 mm rounded soft tissue density most suggestive of mucous retention cyst or polyp. A small focal area of mucosal thickening is seen in the inferior medial right maxillary sinus measuring 4 mm in size. Probably this represents a small mucous retention cyst or polyp or is due to sinusitis.

The left maxillary sinus, sphenoid sinus, ethmoid air cells, and frontal sinuses are well-aerated and clear. The nasal septum is slightly convex to the right without obvious nasal septal spur. The osteomeatal complex bilaterally appears intact.

IMPRESSION:
1. Suspect small mucous retention cyst or polyp in the right maxillary sinus.
2. Small focal area of mucosal thickening in the inferior medial right maxillary sinus may represent a second small polyp or mucus retention cyst versus focal mucosal thickening from sinusitis.

CT SCAN REPORT

09:40:53 10/30/09 O R I G I N A L

CAT SCAN PAGE 2
BEAN, JAMES ROBERT MR# 421788

Dictated on: 10/30/2009 09:34:33
Interpreted by: Dovgan, Daniel J
Transcribed by: <None>
Signed by: Dovgan, Daniel J

ApprovedDate: 10/30/2009 09:39 AM

CT SCAN REPORT